Parkinson’s Specialist Nursing Service

Referral Form *(Post Migration to INTS s1 unit version Feb 23)*

Date of referral: ………………………………………

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| PATIENT DETAILS  Name: D.O.B:NHS Number: | Address: Post Code: Tel. No: |
| REFERRED BY Name: Tel. No: **Address:** Please tick below:- Consultant  GP  Practice Nurse  Specialist Nurse  Hospital Ward Self-referral  Therapist  Other please state: | |

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| **EXCLUSION CRITERIA Referrals received for patients with the following will be declined:-**   * **Patients aged under 18 years old and those NOT registered to a Barnsley GP practice and / or resident within the Barnsley geographical area.** |

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| **INCLUSION CRITERIA (*Please ensure all relevant information is ticked, failure to do so may result in the referral being rejected.)***  **Has the patient been diagnosed with Parkinson’s or have they a Parkinson’s condition? Yes**  **Patients diagnosed with the following conditions can also be referred to the service:**  **MSA- multi system atrophy**  **PSP- progressive supranuclear palsy**  **CBD- corticobasal degeneration**  **LBD-Lewy body dementia.**  ***Please note, one of the above diagnosed conditions must be ticked, if one of the above criteria is not met then the patient’s referral WILL be rejected.*** |

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| **REASON FOR REFERRAL *(Please tick the primary reason for referral):***  **Complex Patient Management  Titration of Medication  Patient Education**  **Advice / Information  Neurological Problems  Long Term Condition Management  Medication Management** |

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| **PAST MEDICAL HISTORY / DISABILITIES** |

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| **MEDICATION** |