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** |