South West Neuromuscular
Operational Delivery Network

NHS

NEUROMUSCULAR ADVISOR REFERRAL FORM

CLIENT REGISTRATION DETAILS:

TITLE		SURNAME		FIRST NAME	
If a child, please provide parent/guardian details					
DOB		GENDER	M / F	NHS NO	
ADDRESS	POSTCODE				
TEL NO		MOBILE			
E-MAIL					
DIAGNOSIS		Is this a confirmed diagnosis?	Y / N		
GP NAME : PRACTICE NAME: TEL NO:					

REFERRAL DETAILS:

REFERRER (Name / Job Title / Organisation)		Tel:	
		E-mail:	

Date of Referral		Date of Diagnosis		Client is aware of Referral	Y / N

CLINICS CURRENTLY ATTENDED (Clinician / Specialty / Hospital)	

REFERRAL CATEGORY (Please check as many boxes as required)	Support at time of diagnosis		Further advice about condition		Emotional Support	
	Support for carers/siblings		Support accessing services & support		Support with School/Employment	
	Transition Support		Support with self-management of condition		End of life planning	
	Other (please specify below)					

Does patient know the diagnosis/anticipated diagnosis?	Y / N	Are there any safeguarding or vulnerable adult issues	Y / N
Will you continue to work with the client/family?	Y / N	Has the patient understood and agreed to this referral	Y / N

ADDITIONAL INFORMATION	

Please return this form to: nbn-tr.neuromuscular-odn@nhs.net or post to South West Neuromuscular ODN, Dept of Neurology, Gate 10, Level 6, Brunel Building, Southmead Hospital, Westbury-on-Trym, Bristol BS10 5NB