MND Wellbeing Programme Referral

Please complete all fields and fax to: 01625 666995

Patient Details

Title: Mr/Mrs/Ms/Miss/Dr/Other
Surname:
Forename (s)
Address:
Postcode
Telephone: Mobile:
Email
Date of birth Ethnicity
Gender: Religion
NHS No:

GP Name
GP address
GP tel no:

Next of kin:
Relationship to patient:
Next of kin address:
Next of kin telephone:
Does the patient live alone?
If “no” to above, who lives with them?

Care support at home (please circle): Independent Family support Outside care (please give details of care package ie number of calls per day/week)

Is the patient aware of this referral?
Does the patient consent to information sharing eg with the GP

Neurology Consultant/MND Nurse Specialist/Location:
Date of diagnosis:
Other general medical conditions/PMH:

Medications:

Allergies:

Specific medical questions regarding the person with MND

(This section MUST be completed in full before we can accept this referral)

Do they use NIV?
If "yes", approx how many hours/day or night?
Do they use a Cough Assist machine?
Do they have a RIG/PEG?
If "yes", please specify if they are still managing oral diet and how PEG routine is managed eg overnight/boluses/water flushes only etc:

How do they communicate? Verbally Written IPAD
Have they completed a DNACPR or any advanced care planning documentation?

Mobility
Please specify mobility (please circle): Independently unaided Independently with an aid (please state type of aid) With help of 1 With help of 2 In wheelchair

Transfers (please circle): Independent unaided Independent with a walking aid with assistance of 1 or 2 with standaid with standing hoist with full hoist

Other relevant information:

Carer Details (Needed so the carer can access services also)

Title:
Surname:
Forenames:
Date of birth: Ethnicity
Gender: Religion:
Address:
Telephone no:
GP Name and address
GP telephone no:

Referrer Details

Name (please print)
Signature
Designation Contact number
Date: