**Parkinson’s community specialist nurse service referral form**

**When complete, submit this form to** [**tsdft.parkinsons-specialist-nurses@nhs.net**](mailto:tsdft.parkinsons-specialist-nurses@nhs.net)

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| **Referrer Details** | **Patient Details** | |
| **Name:** | **Name:** | **DoB:** |
| **Profession:** | **Address and postcode:** | **Gender:** |
| **Address:** |
| **Hospital No.** |
| **NHS No.** |
| **Tel No:** | **Tel No. (1):** | **GP name** |
| **Tel No. (2):** | **GP address and phone** |
| **Email:** | **Carer requirements (has dementia or learning difficulties)?** | **Capacity concerns?**  Yes  No |
| **Decision to Refer Date:** | **Translator Required:** Yes  No  **Language** | **Mobility:** |

**Please attach additional clinical issues list from your practice system**

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| **Current Medication** |
|  |
| **Significant issues, allergies, relevant family history, smoking & alcohol status and morbidities** |
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**Latest metrics if available and relevant**

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| --- | --- |
| **Lying, standing & 3 minute standing BP been recorded?** | **Yes**  **No** |
| **Full blood screen?** | **Yes**  **No** |
| **Anticipatory care guide in place?** | **Yes**  **No** |
| **Current input from physio?** | **Yes**  **No** |
| **Current input from OT?** | **Yes**  **No** |
| **Current input from SALT?** | **Yes**  **No** |

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| **Provider Questions (e.g. primary reason for referral)** | |
| **Increased psychotic episodes & hallucinations, mental health disturbances & confusion?** | **Yes**  **No** |
| **Increased falls (more than normal)?** | **Yes**  **No** |
| **Sudden deterioration in Parkinson’s symptoms?** | **Yes**  **No** |
| **What support do you require from the Parkinson’s community specialist nurse service?** |  |

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| **Relevant past medical history (last 6 months)** | |
| **Is the patient currently under intermediate care?** | Yes  No |
| **If yes, date patient admitted to intermediate care?** |  |
| **If patient is under intermediate care, is there a confirmed infection (i.e. chest, bladder etc.)?** | Yes  No |
| **If the patient has a confirmed infection, give details** |  |
| **Medical history, including type of Parkinson’s, if known:** |  |

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| ***For hospital to complete*** UBRN: | Received date: |