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

**When complete, submit this form to** **tsdft.parkinsons-specialist-nurses@nhs.net**

|  |  |
| --- | --- |
| **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**

|  |
| --- |
| **Current Medication** |
|  |
| **Significant issues, allergies, relevant family history, smoking & alcohol status and morbidities** |
|  |

**Latest metrics if available and relevant**

|  |  |
| --- | --- |
| **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** [ ]  |

|  |
| --- |
| **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?** |  |

|  |
| --- |
| **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:**  |  |

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