

**North Cumbria Neuropsychology Service**

**INADEQUATELY COMPLETED FORMS WILL BE RETURNED TO THE REFERRER**

The North Cumbria neuropsychology service offers cognitive assessment, rehabilitation and adapted psychological therapies to adults living with neurological illness that is impacting on cognitive skills. Referral can be made using this form, or to discuss potential referrals with a member of the team you can also phone to book onto our service wide daily consultation hour, on 01768 245 954.

**Please Note**

* **There are no medical staff in the team. The medical care remains the sole responsibility of the patient’s GP and we are unable to provide a medical diagnosis.**

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| **PATIENT DETAILS:** |  | | Referral Date: |
| **SURNAME:** | **DOB:** | **PRACTICE:**  **Tel:**  **Fax:**  **Practice code:**  **Registered GP:**  **INTERPRETER REQUIRED?**  (if yes, state language including signing)  Yes  No | |
| **FIRST NAME:** | **GENDER:** |
| **PREFERS TO BE CALLED:** | **NHS NUMBER:** |
| **ADDRESS:** | |
| **PHONE:**  Home phone:  Mobile phone:  Work phone: | |

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| **CARE POSITION:** |
| Lives independently  Supported by family/friends  Formal care package in place |
| Additional relevant information if any issues in current care package/if others should be involved in assessment process |

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| **CONSENT:**  The patient gives permission for North Cumbria Integrated Care NHS Foundation Trust (NCIC) and its partner organisations to share their personal details and medical information with other service providers in connection with their care, including accessing and sharing their medical, and if applicable, mental health records. The patient agrees to a referral being made to the Physical Health Rehabilitation Psychology Service (including its associated services) in order to support their healthcare needs. The patient understands that NCIC may hold information gathered about them from various agencies and as such their rights under the Data Protection Act 2018 and UK General Data Protection Regulations (UKGDPR) will not be affected.  the patient has given verbal consent for the information within this referral to be sent to the receiving care team  the patient has given verbal consent for the receiving care team to access the summary / full GP record (where available) for the duration of the period of care, where there is a legitimate reason to do so  the referral has been made through a ‘best interest decision’ |

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| **REFERRAL CRITERIA:** |
| * 18 years or older * Diagnosed neurological condition or is under investigation for a neurological illness * Cognitive problems present or suspected * Requires rehabilitation or adapted psychological therapy to meet needs |

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| **NEUROLOGICAL DIAGNOSIS** | |
| Stroke or other cerebrovascular disease  Multiple Sclerosis  Parkinson’s disease  Brain tumour | Epilepsy  Motor Neurone Disease (will be eligible for 6 week fast track assessment)  Other, e.g. Huntington’s disease, rare genetic disorders: (please specify) |
| Date of diagnosis and current treatment regime: | |

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| **BRIEF HISTORY OF SYMPTOMS:** |
| *(include any treatments / therapies received)* |

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| **RISK INFORMATION:** |
| The patient has identified risk issues. Please specify:  The patient is known to CMHT or ALIS  Patient is under DoLs or a BI process around care  Risks linked with home visits  There are current safeguarding concerns, in relation to this patient and/or the family. Please provide further details:  If **any** of the above options are ticked, please enclose relevant letters and reports. |

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| **REFERRER DETAILS:** | |
| **NAME:**  **DESIGNATION:** | |
| **SIGNATURE:** | **DATE:** |

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| **EMAIL REQUEST TO:** |
| PhysicalHealth.Psychology@ncic.nhs.uk |

**Note to provider: this referral form has been standardised locally in line with the required NHS minimum requirements and guidance from Information Governance. Please email** [**primis@ncic.nhs.uk**](mailto:primis@ncic.nhs.uk) **with any proposed amendments to the form.**