Parkinson's Nurse Specialist Referral Form
Redbridge

NELFT NHS
NHS Foundation Trust
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*****Incomplete form will be rejected and returned to referrer for completion*****

Email: nem-tr.redbridgeltc@nhs.net
Tel No: 0300 300 1826 **Date:.....**

Patient Details

Forename	Surname	
Date of Birth	Gender ☐ Male ☐ Female	NHS Number
Address and Postcode: Mobile:	Landline:	
Ethnicity: Religion:	1st Language: Interpreter Required: Yes ☐ No ☐	Has patient consented to referral? Yes ☐ No ☐
Next of Kin Name:	Relationship to Patient:	
Next of Kin contact number:		
Patients GP:	Practice Name:	
GP address :		
GP Phone:	Email:	

Parkinson's History

Date Diagnosed:

Diagnosis: ☐ Newly Diagnosed ☐ Maintenance ☐ Palliative
☐ Parkinson's Disease with Dementia ☐ Complex – 2 different types of medication

Current Parkinson's Medication (if applicable):

Other Current Medication:

Reason Referral

☐ Medication Review ☐ Advice and Information ☐ Falls ☐ Cognitive decline ☐

Other:

Other Medical Conditions:

Source of Referral

Name:	Job Title:
Organisation/Practice Name:	
Address/Ward:	
Phone:	Email