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| **Date: NHS:** **Surname:** **Forename: Date of birth:** **Address:** **Postcode:** **Tel: …...................................... Mob: …........................................****Mob:** **Email:** **….............................................................**  **Consent Y/N****Ethnicity: …..................................................................................****Main Language: .……………………………………………………..** | **GP Name:** **Practice:** **Postcode:** **Tel:**  |
| Diagnosis: |
| **NB**: The service only sees patients witha primary***neurological*** diagnosis.Date of diagnosis: |
| **Reason for referral/presenting problem/input to date (inc. date of onset if appropriate)***Please attach any relevant documents and continue on next page if necessary**eg medical report, GP summary etc.* |
| **Is patient able to attend a Clinic Appointment? YES or NO (delete as appropriate)** |
| Routine waiting time is from 20 weeks. Please specify if needs input sooner. |
| **Referrer’s Name:** **Address:** **Tel:**........................................................... **Email:** …........................................................................................... **Relationship to client: Client aware of referral?: Y/N** **Any information to ensure therapists access/safety? Y/N Details:** |

* Email to:PDPSReferral@oxfordhealth.nhs.uk
* Post to: Jane Stoackley, PDPS Administrator, Abingdon Community Hospital, Marcham Road, Abingdon, Oxon OX14 1AG

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| **Referral information –** *continued* |