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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](mailto: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* |