

**Kent Clinical Neuropsychology Service Referral Form**

**The person you are referring:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Their name:** |  | **Address:** |  |
| **Home telephone:** |  | **Mobile:** |  |
| **Dob:** |  | **NHS number:** |  |
| **Next of kin name:** |  | **Next of kin telephone numbers:** | Home telephone:  Mobile telephone: |

|  |  |
| --- | --- |
| **Their neurological diagnosis:** |  |
| **NB:** Our referral criteria is listed on our website: [**http://www.kmpt.nhs.uk/kcns**](http://www.kmpt.nhs.uk/kcns) | |
| **Relevant current and past medical information (including brain scan results):** |  |
| **Their current medication:** |  |

**Reason for referral** (please select all the appropriate check boxes that apply):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Reason for referral** | Neuropsychological therapy | Cognitive assessment | **Cognitive rehabilitation** | Family or couple’s intervention | Return to work/  vocational support | Concerns about client’s behaviour | Consultation (i.e. for teams, care staff) |
|  |  |  |  |  |  |  |
| **Please provide further details about the presenting problems:** | **PLEASE ENCLOSE ANY RECENT HOSPITAL DISCHARGE SUMMARIES, GP**  **ENCOUNTER SHEETS OR OTHER RELEVANT REPORTS/DOCUMENTATION** | | | | | | |

**Gender, relationship status, housing and employment details for the person you are referring**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Self-identified gender:**  (please select appropriate checkbox) | Male | | | | **Relationship status:** | Married |  | Widowed/ surviving civil partner |  |
| Female  Non-binary | | | | Single |  | Divorced/ person whose civil partnership has dissolved |  |
| Separated |  | Not disclosed |  |
|  | | | | Civil partnership |  | Not known |  |
| **Housing:** | Owner-occupier |  | Homeless |  | **Employment status:** | Unemployed |  | Not receiving benefits, not working, not seeking work |  |
| Tenant-private landlord |  | Tenant-local authority |  | Working |  | Long-term sick/disabled, receiving benefits |  |
| Other |  |  |  | Retired |  | Unpaid voluntary work |  |
|  | Student |  | Unemployed & seeking work |  |

**Ethnicity of the person you are referring**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **White:** | | **Mixed race:** | | **Asian / Asian British** | | **Black / black British** | | **Other ethnic groups** | |
| White British |  | White and black Caribbean |  | Indian |  | Caribbean |  | Chinese |  |
| Irish |  | White and black African |  | Pakistani |  | African |  | Any other ethnic group |  |
| Any other white background |  | White and Asian |  | Bangladeshi |  | Any other black background |  | Not stated |  |
|  | | Any other mixed background |  | Any other Asian background |  |  | |  | |

**Additional information**

|  |  |
| --- | --- |
| **Current and past mental health history:** |  |
| **Relevant social information (relationships, work, housing, financial):** |  |

**Access**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Is the person able to travel to a clinic?** Yes  No | | | | | | |
| **Is the person a wheelchair user?** | Yes | No | **If yes**  **Is it a standard or bariatric chair?** | Standard | Yes | No |
| Bariatric | Yes | No |
| **Is client’s first language English?** | Yes | No | **If no, is an interpreter required?** | Yes | No | |
| Client’s preferred language: | | |

**Risks**

|  |  |  |
| --- | --- | --- |
| Are there any particular risks that we need to be aware of when working with this person and/ or people around them? (I.e. risk of harm to client, harm to others or accidental harm). | Yes | No |
| Please provide details: | | |

**Consent**

|  |  |  |
| --- | --- | --- |
| Does the individual have the mental capacity to consent to this referral? | Yes | No |
| If yes, have they provided their consent? | Yes | No |
| If no, has this been made in their best interests? | Yes | No |
| Is the individual’s next of kin aware of this referral? | Yes | No |

**Other professionals who are currently involved with the person:**

|  |  |  |
| --- | --- | --- |
| **GP** | GP name:  GP practice: | GP telephone number:  GP email address: |
| **Social services:** | Case manager name: | Telephone number:  Email address: |
| **Others:** |  | |

**Referrer details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Your name:** |  | **Today’s date:** |  |
| **Your email address:** |  | **Your telephone numbers:** | Office:  Mobile: |
| **Your work address:** |  | **Your job title:** | Job title: |

**Returning your referral**

|  |  |
| --- | --- |
| **East Kent** | Kent Clinical Neuropsychology Service, Disablement Services Centre, Medway Maritime Hospital, Gillingham, ME7 5NY  Tel: 01634 833937  Email: [KAMNASCPT.neuropsych@nhs.net](mailto:KAMNASCPT.neuropsych@nhs.net) |
| **West Kent** | Kent Clinical Neuropsychology Service, Darent House, Hospital Road, Sevenoaks. TN13 3PG  Tel: 01732 228226  Email: [KAMNASCPT.npsychadminwest@nhs.net](mailto:KAMNASCPT.npsychadminwest@nhs.net) |
|  | **Has all relevant documentation been included with the referral?**  Yes  No |

**Please complete all sections: uncompleted forms may be returned to the referrer**