

**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 5NYTel: 01634 833937Email: KAMNASCPT.neuropsych@nhs.net |
| **West Kent** | Kent Clinical Neuropsychology Service, Darent House, Hospital Road, Sevenoaks. TN13 3PGTel: 01732 228226Email: 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**