Neurology Support Centre Referral Form

Name: ……

Address: ……

Town: …… **County:** ……

Eircode: ……

Date of birth: …… **Gender:** ……

Home phone: …… **Mobile:** ……

Email: ……

Next of kin name: ……

Relationship: ……

Home phone: …… **Mobile:** ……

Email: ……

Please indicate what services you may be interested in:

☐ **Peer support group** ☐ **Holistic Therapies** ☐ **Counselling**

☐ **Social / recreational** ☐ **Information & advice** ☐ **Transport**

☐ **Other suggestions** ……

By signing below, you are consenting to the following:

- That the Neurology Support Centre may store your information in accordance with our Privacy Policy.
- That the Neurology Support Centre may provide and seek information, advice, and support from other medical or support organisations in relation to the patient named
- That the Neurology Support Centre may contact you occasionally in relation to our services and activities.
- (For patients only) That we may contact your next of kin if we feel it necessary to protect your health.

You can withdraw your consent at any time

Patient Signature _____ **Date** _____

Mandatory unless under 18

Next of Kin signature _____ **Date** _____

Mandatory for patients under 18, optional otherwise

Medical Information

To be completed by your Neurologist/GP or other medical professional

Diagnosis:

Date of diagnosis:

Name of Neurologist:

Location:

Name of GP:

GP Tel No:

Please enter any other relevant medical history and any other relevant information including contraindicated therapies:

Signature: ……

Role: ……

Stamp/Date: ……..