

**North East Drive Mobility (NEDM)**

**Health Professional Referral Form**

**Passenger** [ ]  **Access**[ ]  **Stowage**[ ]

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| Please complete as much information as possible; if you would like to discuss any aspect of your referral, please contact North East Drive Mobility Tel: 0191 2875090**If you are referring from CNTW NHS Foundation Trust PLEASE NOTE: North East Drive Mobility does not have access to Mental Health records held by CNTW on RIO so please enclose any information that is appropriate for the referral.** **Please tick which Centre your client would like to attend:Newcastle upon Tyne 🞎Carlisle 🞎Teesside (Stockton-on-Tees) 🞎****Home visit** [ ]  |
| **Section A: Personal details** |
| Full name:  |  |
| DOB: |  |
| Address: | If the client is not currently at their home address, please provide details: |
| Contact Information: | Home phone: Mobile: Email:  |
| Are there any known risk behaviours relating to your client, e.g. aggressive behaviour, which the assessment team need to be aware of? | Yes [ ]  No [ ]  |
| If yes, please provide details: |
| Are you aware of any allergies that your client may have? | Yes [ ]  No [ ]  |
| If yes, please provide details: |
| **Please note date referral created:** |
| Please tick this box to confirm your client has been made aware of the service NEDM provides, and have provided consent to this referral. (**We will be unable to proceed with the referral if consent for assessment has not been given**) [ ]  |
| **Section B: Referrer details** |
| Name:  |  |
| Role:  |  |
| Address: |  |
| Tel number:  |  |
| Email:  |  |
| **Section C: GP details**  |
| If you are not the client’s GP, please provide us with their GP details |
| GP Name: |  |
| GP Practice: |  |
| Address: |  |
| Tel number: |  |
| **Section D: Medical history and current functioning** |
| Diagnosis: |
|  |
| Relevant past medical history (please include any relevant cognitive assessment results): |
| Height: Weight: |
| Please list any current medication: |
|  |
| How does the client’s medical condition affect them? (E.g. physical functioning, cognition etc.) |
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| How does the client mobilise? Please detail any mobility aids you are aware of currently used (E.g. wheelchair, walking stick, walking frame, mobility scooter) |
|  |
| How does the client currently transfer? (e.g. independently, with assistance or with aids) |
|  |
| Are there any issues you are aware of relating to the following? |
| Vision: Yes [ ]  No [ ] Seizures: Yes [ ]  No [ ] Recent surgery: Yes [ ]  No [ ]  If yes to any of the above, please provide details: |
| **Section E: Passenger/Access/Stowage** |
| Current vehicle make and model:  |
|  |
| Current difficulties  |
| Passenger (posture, transfers) [ ] Details:Transferring to drive [ ] . Details:Stowing equipment [ ] Details: |
| Are there any specific difficulties in relation to the following: |
| Travel sickness: Yes [ ]  No [ ]  Communication: Yes [ ]  No [ ]  Behaviour: Yes [ ]  No [ ]  Seizures: Yes [ ]  No [ ]  If yes to any of the above, please provide details below: |
| **Section F: Other** |
| Is an interpreter required?  | Yes [ ]  No [ ]  |
| If yes, please give details: |
| Are there any carers or professionals that need to be present for the assessment: | Yes [ ]  No [ ]  |
| If yes please give details: |
| Please detail any other relevant information below: |
| If you would like to attach any other documentation to the referral e.g. copy of clinic/consultation letter, please do so. |

Once you have completed the form either:

1. **Print off and send by post to: Mobility Clinician, North East Drive Mobility, Walkergate Park, Benfield Road, Newcastle upon Tyne, NE6 4QD**
2. **Send the form electronically as an attachment and a covering email to North East Drive Mobility at: northeast.drivemobility@cntw.nhs.uk**

V2 – September October 2021