Parkinson's Nurse Specialist Service
Health Professional Referral Form

Important:

- Complete all relevant sections.
- Information regarding the Parkinson's Nurse Specialist service can be found online HERE
- Referrals to the Parkinson's Nurse Specialist service using this form will only be accepted from health practitioners.
- The criteria for referral to the Parkinson's Nurse Specialist service is a medical diagnosis of Idiopathic Parkinson's or an Atypical Parkinsonism (Multiple System Atrophy (MSA), Progressive Supranuclear Palsy (PSP) or Cortico-Basal degeneration (CBD)).
- Please note that the Parkinson's Nurse Specialist service is not an emergency or crisis service.
- Email or Fax only one patient/client referral at a time and please only send one referral per client/patient.

Please email completed forms to Parkinson's WA: info@parkinsonswa.org.au or Fax: 08 6457 7374

Referrer Details

Name of Referrer:		**AHPRA Registration Number:**	
Organisation Name:		**Referrer Role:**	
Referrer Email:		**Referrer Phone:**	

Patient/Client Details

First Name:		**Last Name:**	
DOB (dd/mm/yyyy):		**Date of Parkinson's Diagnosis** (yyyy):	
Diagnosed Condition	☐ Parkinson's ☐ MSA ☐ PSP ☐ CBD ☐ Other:		
Home address:			
Patient Phone Number:		**Can the patient be contacted by phone?:**	☐ Yes ☐ No
Patient Email:			

Primary Reason for Referral

Description of problem or issue as identified by the referrer or patient, for example relevant medical conditions, reason for admission, mobility, fall risk or cognition issues.

Type Here:

Additional Information

Type Here:

Additional Patient/Client Details

GP Name:	
Neurologist Name:	
Geriatrician Name:	

Patient/Client Carer Information

Does the patient have a carer/support person?	☐ Yes ☐ No
Usual Living Arrangements:	☐ Alone ☐ With Family/Partner/Carer ☐ Aged Care Facility Other:

Details of Carer/Support person:	Name:		Ph:	
	Relationship to the Patient:	☐ Partner ☐ Child ☐ Friend ☐ Support Worker Other:		
Does the carer/support person need to be present during nursing assessments?		☐ Yes ☐ No		

Consent For Referral

Has consent been provided for this referral?	☐ Yes ☐ No

If not patient, consent provided by:		**Ph:**	
Relationship to the Patient:			
Reason if not the Patient:			

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Save Completed Form | Print Form | Email Form to Parkinson's WA | Clear Form

Office Use

Date of Referral:		**Referral Number:**	
Date of Contact:		**Date of 1st visit:**	

	Notes
Pets	
Living alone	
Altered mental state	
COVID-19 App	