**Movement Disorders Coordinator**

Western NSW Local Health District

Telephone: 0407171542

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**REFERRAL FORM**

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| **PATIENT’s NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **AUID/MRN:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PHONE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **TOWN:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **GP NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PRACTICE NAME:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Aboriginal or Torres Strait Islander Origin: Yes No** |
| **Has Verbal Consent for this referral and Information sharing been obtained from this person?**  **Yes No** |
| **Referral Submitted by:**  **NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ROLE/ TITLE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ORGANISATION:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PHONE NUMBER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE of REFERRAL:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Referral Criteria:**  This program is elegible to all people living in Western NSW LHD who are over the age of 21 and have a diagnosis of the following Movement Disorders (please tick) :  Parkinson’s Disease Huntington’s Disease  Progresive Supranuclear Palsy (PSP) Multiple System Atrophy (MSA)  Corticobasal Syndrome (CBS)  Other movement disorder please specifiy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The following neurodegenerative conditons will be also be accepted:  Multiple Sclerosis (MS)  Motor Neuron Disease (MND) |
| Please identify if this person is:  At risk of hospitalisation  Needing more information about their diagnosis or disease  Needing more care co-ordination than can be provided by General Practice  Having diffiuclty accessing and using the right services for their care  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Does the person have a Carer/Guardian? Yes No**  **Carer/guardian name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**GOALS and ACTIONS**

* Conduct a comprehensive, holistic, person centred assessment.
* Link the patient and family with appropriate community based services providing support for daily living and social needs.
* Assist the client to navigate health and disability systems.
* Help the patient/carer better understand all aspects if their disease across the disease continuum through health education and advice.
* Provide support to the patient and their family to develop self-management skills for their health and social needs
* Provide a link between client needs, primary health care, health professionals, social care providers and acute services.