

Motor Neurone Disease Association referral form

Please complete both sections of this form and return by email to careadmin@mndassociation.org or by fax to 01604 638289 ensuring that the file is password protected. If you have any queries, please call 0808 802 6262.

The completion and submission of this form confirms that the person with MND has consented to the MND Association keeping a record of their details which will be stored securely in accordance with the requirements of Data Protection Regulations

The following sections are optional* and can be left blank if you prefer not to answer: <ul style="list-style-type: none"> Date of birth Gender Ethnicity Sexual orientation Religion 	Person with MND	Main informal carer The person that provides/would provide nonpaid care and support on a regular basis for example, Spouse, Partner, Parent, Family member/Friend.
Title (Appendix A)		
First (and other) name(s)		
Surname/Family Name		
Known as/Preferred Name		
Address Line 1		
Address Line 2		
Address Line 3		
Postcode		
Date of birth		
Gender (Appendix A)		
Ethnicity (Appendix A)		
Sexual orientation (Appendix A)		
Religion (Appendix A)		
Telephone (home)		
Telephone (mobile)		
Email		
Preferred method of contact		
Relationship to person with MND		
NHS Number (if known)		
Date symptoms started		
Date of diagnosis		
Type of MND		
Care Centre		

*Further guidance on use of data relating to age, gender, ethnicity, sexuality, and religion can be found at **Appendix A**

Name of GP	
Surgery address	
Telephone	
Email	

Name of Neurologist	
Work address	
Telephone	
Email	

Name of referrer	
Job title	
Organisation	
Address	
Telephone	
Email	

Additional information. Please use this space to advise of any other relevant information that will assist us with supporting the person with MND (for example, speech difficulties, English not first language).

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Children and Young People support	
<p>Children and Young People aged 18 and under (or up to 21 where the child or young person has additional needs). We offer a wide range of support for children and young people who are affected by MND.</p> <p>No. of children and young people living with person with MND <input type="text"/></p> <p>No. of children and young people affected who live elsewhere <input type="text"/></p> <p>Person with MND would like information about Children and Young People services <input type="checkbox"/></p>	
<p>Please detail below the name and date of birth of each child or young person requiring support – this is so age-appropriate information and support is provided</p>	
<p>Children and young people living with the person with MND</p>	<p>Children and young people affected and who live elsewhere</p>

Support Volunteers

The Association has a network of Support Volunteers who perform a vital role in supporting people affected by motor neurone disease – both those living with the disease and those close to them. All are volunteers who have been carefully selected and have undergone a thorough training programme. The Support Volunteers are based in the local community as members of a team and can offer support virtually, over the phone or via e-mail, or will visit them in their own home.

We also have a network of Branches and Groups and some offer support via meetings.

Please note that we do not have visitors available in every area of England, Wales and NI, however we can offer on-going support and help through regular contact with MND Connect (our Helpline) and in other ways if required.

(please tick relevant box below)

Person with MND would like information about Support Volunteer services

Person with MND would like information about local Branch / Group support

I confirm that this form has been completed in conjunction with, and with the permission of the person with MND.

Signature of referrer: _____ **Date** _____

Name of referrer (block capitals): _____

We would like to know what information you are interested in receiving and how you would like us to contact you in the future. You can change your mind at any time.

Your Information	Person with MND's name		Main Informal Carer name
	_____	_____	_____
	YES	NO	N/A
Sharing information with local health and social care professionals I agree that the Association can share information and discuss my needs with local Health and Social Care Professionals and services involved in my care and support.			

MND Association Services, Updates, Membership and Information	Person with MND		Main informal Carer	
	YES	NO	YES	NO
Our services I would like the Association to keep me updated on the services it provides and funds. This could include local newsletters on activities taking place in my area.				
Updates I would like the Association to send me updates on the work being done locally and nationally including ways to get involved or help. These updates could include information about volunteering, ways of helping in our campaigning activities or in supporting the Association financially.				
Association membership I agree to become a member of the Association and receive a welcome pack and the quarterly magazine Thumb Print. More details will be included in the welcome pack. <i>Note: We provide support to people affected by MND regardless of whether they are a member or not.</i>				
Communication preferences I agree to receive these communications by the following methods. (You can select more than one option).	Post	Email	Post	Email

You can stop receiving information or change your consent(s) at any time.
Email mndconnect@mndassociation.org or call 0808 802 6262. Full details on how we use your information can be found at www.mndassociation.org/privacy-policy

Signature (Person with MND): ** _____ **Date:** _____
Signature (Main informal carer) : _____ **Date :** _____

**** If the consent section of this form is not signed by the person with MND, you must include your full name and signature as confirmation that the information has been captured in accordance with the person with MND's request.**

Signature: _____ **Date:** _____
Full name (block capitals): _____

In addition to using data relating to age, gender, ethnicity, religion and sexual orientation to ensure that the best possible support can be provided, the Association also uses such data to ensure that it is reaching as many people as possible and that certain groups of people are not excluded or are not aware of the services that can be offered. Data used for such purposes is anonymised and cannot be attributed to or associated with an individual.

Ethnicity

Please enter a code in the box from the final column or F01 if you would prefer not to say

A-White	English/ Welsh / Scottish / N Irish / British Irish Gypsy or Irish traveller Any other white background	A01 A02 A03 A04
B-Mixed / multiple ethnic groups	White and Black Caribbean White and Black African White and Asian Any other mixed / multiple background	B01 B02 B03 B04
C-Asian / Asian British	Indian Pakistani Bangladeshi Chinese Any other Asian background	C01 C02 C03 C04 C05
D-Black/African/Caribbean/Black British	African Caribbean Any other Black / African / Caribbean background	D01 D02 D03
E -Other ethnic group	Arab Any other ethnic group	E01 E02
F	Prefer not to say	F01
Unknown		U01
Any other		O01

Title	Gender	Sexual Orientation	Religion
Mrs	Male	Heterosexual	Christian
Mr	Female	Lesbian	Muslim
Miss	Non-binary	Gay	Hindu
Ms	Trans	Bisexual	Buddhist
Mx	Other	Other	Jewish
No title			Atheist
			Jain
			Sikh
			Other

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Business owner	Pauline Matheson-Marks