UHSM Your Hospital

University Hospital of South Manchester NHS
NHS Foundation Trust

Patient Referral Registration Form

Expert Patients Programme PR1

Please **DO NOT** refer if **either** of the following applies:

*** Unstable Mental Illness * patient is under 18 years of age**

Details of GP _____ Practice Name _____ Address _____ _____	Details of Referrer Name _____ Position _____ Address _____ Post Code _____ Contact Number _____ Email _____
Where did you hear about the Expert Patients Programme? Preferred course venue or starting date (if known) _____	

Personal Details

First name:	Surname:
Address:	Post code:
Telephone number:	Mobile phone number:
Date of Birth:	Occupation:

Individual Needs

What is your long-term health condition?	
Do you need to bring a carer with you?	
Do you have any special dietary needs?	
Please could you put a Contact Name & number in case of emergencies during the course only?	

Please state your Ethnic Background

White	White British		White Irish	White other
Mixed	White & Black Caribbean	White & Black African	White & Asian	Other mixed background
Asian or Asian British	Asian-Indian	Asian-Pakistani	Asian-Bangladeshi	Other Asian background
Black or Black British	Caribbean	African	Any other black background	
Chinese or other	Chinese	Other ethnic group	I do not wish to disclose this	Not stated

Gender Gender Equality Duty 2007	Male	Female	Transexual	I do not wish to disclose this		
Age Group	18-30	31-50	51-65	65+	I do not wish to disclose this	
Sexuality	Lesbian	Gay	Bisexual	Heterosexual	I do not wish to disclose this	
Religion or belief	None	Christianity (please specify)		Islam	Jainism	Hinduism
	Sikhism	Judaism	Buddhism	Other	I do not wish to disclose this	

Do you consider yourself to have a disability?	**Yes** If yes please continue below	**No**	
Please state the type of impairment which applies to you. People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply, please mark 'Other'.	Physical Impairment	Sensory Impairment	Mental Health Condition
	Learning disability/difficulty	Long-standing illness	Other: please state

What is your first language?	**Do you need an interpreter?**

Special Needs / Requirements	
In order to ensure adequate provision to meet the needs of people with a disability attending the courses please state if you require any of the following: portable loop system; electronic handouts; handouts printed on coloured paper; Braille etc	
Please state if you use a mobility aid such as a wheelchair, walking stick or frame	
Please advise us if there any other requirements that may not be listed above	

The Personal Information contained within this form is for use by the Expert Patients Programme team and is covered by the Data Protection Act 1998.

At the end of the course we will notify your GP and/or referrer (if relevant) that you have completed the course. If you do not want us to copy your discharge summary sending to your GP please complete the section below.

(Name) I _____do not want a copy of the discharge summary sending to my GP.
In order to maintain the standards, we may ask you to fill in questionnaires so that we can monitor the effectiveness of the programme. All the information you provide will be treated as confidential. This additional information is given on a voluntary basis and will not affect your place on the course.

Please return completed form as soon as possible to
Expert Patients Programme Team,
University Hospital South Manchester, NHS Foundation Trust
Newton Silk Mill,
Holyoak Street, Newton Heath,
Manchester, M40 1HA
Telephone 0161 219 9424

If you have any questions or concerns about local NHS Services, please contact the Patient Advice and Liaison Service (PALS) on 0161 219 9451