

Motor Neurone Disease Association referral form

The Motor Neurone Disease (MND) Association focuses on improving access to care, research and campaigning for those people living with or affected by MND in England, Wales and Northern Ireland¹. If you or someone you know has been diagnosed with MND and would like our help and support, please complete both sections of this form and return by email to careadmin@mndassociation.org or by post. We would recommend that, if you are able to, you send the form in a secure manner, for instance by using password protection. If you have any queries, please call 0808 802 6262.

For information about how personal information on this form will be handled, please see our Privacy Notice available at www.mndassociation.org/service-privacy-notice.

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 	Person with MND	Main informal carer
Title		
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*		
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		

¹ MND Association is registered in England with Charity no. 294354. To understand more, please visit <http://www.mndassociation.org>

GP Name & 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).

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>Please tick to confirm if the 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>	
Children and young people living with the person with MND	Children and young people affected and who live elsewhere

Support Volunteers

The MND Association has a network of Support Volunteers who perform a vital role in supporting people affected by MND – 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 where the Patient is not able to complete this form, it has been completed in conjunction with, and with the permission of the person with MND.

Signature of Person with MND or of referrer (where the Person with MND is not able to sign the consent form) : _____

Name (Details of Person with MND, if signing on behalf of them):

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/service-privacy-notice				

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): _____

This section is completely optional. In addition to using data relating to 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.

I am happy for the association to hold and process this information about me: **Yes** **No**

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

Sexual Orientation	Please tick as appropriate	Religion	Please tick as appropriate
Heterosexual		Christian	
Lesbian		Muslim	
Gay		Hindu	
Bisexual		Buddhist	
Other		Jewish	
		Atheist	
		Jain	
		Sikh	
		Other	

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