Department of Clinical Neuropsychology
Salford Royal Hospital,
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Salford
M6 8HD
Telephone: 0161 2064694
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Website: http://www.manchesterneurosciences.com/departments/neuropsychology/nead

Non-Epileptic Attack Disorder (NEAD) Service Referral form

Referral criteria

Please note that the NEAD service is only able to accept referrals where the following criteria have been met

- The patient is aged 16 or over
- A confirmed diagnosis of NEAD has been made by either a neurologist or neuropsychiatrist
- All investigations that might have a bearing on the diagnosis have been completed
- The NEAD diagnosis has been explained to the patient
- The patient understands and accepts the NEAD diagnosis
- The patient is aware of this referral to the NEAD service

Referrals can only be accepted from outside the greater Manchester area if the patient is referred by a Manchester Centre for Clinical Neurosciences (MCCN) Neurologist or Neuropsychiatrist

Referral information

Please provide the following information, which will help us to assess the suitability of the referral for our service.

Patient's details	
SRFT Hospital Number *(if available)*	**xxxxxx**
Name	Click here to enter text.
D.O.B	Click here to enter a date.
Address	Click here to enter text.
NHS Number	Click here to enter text.

Telephone Number	Click here to enter text.
E-mail address (optional)	Click here to enter text.
GP Name	Click here to enter text.
GP Practice Address	Click here to enter text.
Referrer's Details (if not GP)	
Name	Click here to enter text.
Occupation	Click here to enter text.
Address	Click here to enter text.
Telephone Number	Click here to enter text.
E-mail address (optional)	Click here to enter text.

Please answer the following questions by selecting the appropriate response and providing details as necessary:		
Has a confirmed diagnosis of NEAD been made?	**Yes** ☐	**No** ☐
If yes, who made the diagnosis? Name: Click here to enter text. Profession/ specialty: Click here to enter text.		
Are there any outstanding medical investigations that could affect the NEAD diagnosis?	**Yes** ☐	**No** ☐
If yes, please provide details: Click here to enter text.		
Is the patient aware of this referral?	**Yes** ☐	**No** ☐

Have you provided the patient with details of our website? http://www.manchesterneurosciences.com/departments/neuropsychology/nead	**Yes** ☐	**No** ☐
Does the patient have a diagnosed Learning Disability?	**Yes** ☐	**No** ☐
If yes, please provide details: Click here to enter text.		
Does the patient have a forensic history?	**Yes** ☐	**No** ☐
If yes, please provide details: Click here to enter text.		
Does the patient have any special requirements that we should bear in mind when arranging appointments? *(e.g. interpreter, need for large print letters or easy read documents)*	**Yes** ☐	**No** ☐
If yes, please provide details. Click here to enter text.		

Further details about the reason for this referral:

Click here to write your response

Please return this form by e-mail or post:

reftoneuropsych@srft.nhs.uk

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