

# Patient Referral Registration Form

Expert Patients Programme PR1



Manchester Community Health

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 (if relevant) Name _____ Position _____ Address _____ Post Code _____ Contact Number _____ Email _____
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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 and number in case of emergencies during the course only?	

## Please state your ethnic background

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



<b>Gender</b> Gender Equality Duty 2007	Male	Female	Transsexual	I do not wish to disclose this	
<b>Age Group</b>	18-30	31-50	51-65	65+	I do not wish to disclose this
<b>Sexuality</b>	Lesbian	Gay	Bisexual	Heterosexual	I do not wish to disclose this
<b>Religion or Belief</b>	None	Christianity (please specify)		Islam	Jainism      Hinduism
	Sikhism	Judaism	Buddhism	Other	I do not wish to disclose this
<b>Do you consider yourself to have a disability?</b>			<b>Yes</b> If yes please continue below	<b>No</b>	
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
<b>What is your first language?</b>					
<b>Do you require an interpreter?</b>					
<b>Special Needs / Requirements</b>					
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, large print, 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 a copy of 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 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, NHS Manchester,  
Manchester Community Health, Newton Silk Mill,  
Holyoak Street, Newton Heath,  
Manchester, M40 1HA  
Telephone 0161 291 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

