**Referral Form – Active Neuro**

*Return to* *midwest@ms-society.ie* *or to Susan Coote, MS Ireland, Mid-West Regional Office, ‘Tara’, St. Nessans Road, Ballykeefe, Limerick*

Referrer Details: *(self/people with neurological conditions, charities and healthcare providers can refer)*

|  |
| --- |
| Name: |
| Contact number:  | E-mail: |

Inclusion criteria:

Diagnosed with neurological condition 

Medically Stable/Post rehabilitation phase 

Over 18 

Consent from participant to share information below with MS Ireland 

Participant Details:

|  |  |
| --- | --- |
| Participant Name:  | DOB: |
| Address:  | Telephone:E-mail:  |
| GP Name and Contact details: | Consultant: |
| Neurological diagnosis: | Date/year of onset: |

**Mobility status:**

0 Walking is not affected. 

1 Walking is affected but patient is able to walk independently. 

2 Usually uses unilateral support (single stick or crutch, one arm) to walk outdoors, but walks independently indoors. 

3 Usually uses bilateral support (two sticks or crutches, frame/rollator, or two arms) to walk outdoors, or unilateral support (single stick or crutch, or one arm) to walk indoors.

 4 Usually uses wheelchair to travel outdoors, or bilateral support (two sticks or crutches, frame, or two arms) to walk indoors. 

5 Usually uses a wheelchair indoors. 

**Has the participant had a fall in the past 3 months?**

If yes, please give number of falls in past 3 months \_\_\_\_\_

**Suggested/Preferred Programme:**

***Better Balance*** – fall in past 3 months, independently mobile at community level with or without an aid

***Step it up*** – currently active less than 30 minutes one or 2 days per week, diagnosed <4 years, use at most 1 stick to mobilise outdoors

***Community walking programme*** – independently mobile at community level with or without an aid

***Other suggested programme***/**s** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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