



**Please return to:**  
**Macmillan Wellbeing Centre**  
**Moorside Rd, Davyhulme M41 5SN**  
**Tel: 0161 746 2080**

**\* AGED OVER 18 Y / N**  
**\* RESIDENT IN TRAFFORD, OR REGISTERED WITH A TRAFFORD GP Y / N**  
**IF NO – PLEASE SPEAK TO A MEMBER OF STAFF**

Office use only ID No:  Date ref received:	<b style="color: red;">Allergy sticker</b>
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**Title:**  
**Name:** **Date of Birth:**  
**Address:** **Sex:** M  F   
**Marital Status:** M / W / D  
**Ethnicity:**

Other family members being seen Y / N Details :
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**Postcode:**

**Phone:** Home: Work/Mobile:  
**Is client happy for us to leave a voice message** Yes  No

**NHS Number (if known):**

**GP:** **GP Phone:**  
**GP Address:**

**Consultant:** **Hospital Attending:**

**District Nurse/Macmillan Nurse:** Name:  
 Phone:

**Emergency Contact Name:** **Phone:**  
**Address:**

**Referred by:** Self  **Referral Date:**  
 Other  Name and Relationship to client .....  
 Professional  Name and professional role / designation .....

**Address (if referred by Professional):** **Phone:**

**Method of Referral:** Phone \*\*  Face to Face\*\*   
 Fax  Letter  (Date on letter.....)

**\*\* Referral taken by (if applicable)**

**Does the client understand and accept the referral?** Yes  No

**Presenting Issues (eg anxiety):**

**Diagnosis:**

**Current Situation:**

**Adjustments Required:**

**Any accessibility adjustments (eg wheelchair) Details:**

**Interpreter required Y / N Details:**

**Any other relevant information:**

**For Office Use Only**

**NOK Details taken Y / N**

**Any adjustments required Y / N**

**Any Allergies Y / N**