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| **Section A: Details of person to receive Healthcare Services** | | | | |
| First name: | | Surname: | | |
| Address including postcode: | | | | Telephone number (mobile if possible please): |
| Date of Birth: |
| Email address: | | | | |
| My diagnosis (please tick):  I have a diagnosis of M.E.  I have a diagnosis of CFS  I don’t have a formal diagnosis | Based on the definitions in the [NICE guideline for M.E./CFS](https://www.nice.org.uk/guidance/ng206/chapter/recommendations#box-1-severity-of-mecfs), my symptoms are:  mild  moderate  severe  very severe | | | |
| My GP’s name and address: | | | I would like to be referred to a (please tick all that apply):  Doctor  Physiotherapist  Counsellor  Chaplain | |
| **PLEASE NOTE All Healthcare Services incur a charge, which we ask for only to cover our costs. We aim to keep our fees affordable, and bursary support with up to 50% of fees may be available, depending on your circumstances. See Section D of this form.** | | | | |
| I am seeking support with (please give a BRIEF summary): | | | | |
| The best way to communicate with me is (please tick):  Phone  Email  **PLEASE NOTE we may sometimes send a text to your mobile phone to highlight the offer of an appointment which has been sent by email.** | | | | |
| Best time/s of day to contact me: | | | | |
| **Section B: Data protection and consent – please read, then sign and date** | | | | |
| You can find further information about how we process and use your data by reading our Privacy Policy, available online at [www.actionforme.org.uk/privacy](http://www.actionforme.org.uk/privacy) or we can send you a copy by post. We will use your email/telephone number to keep in contact with you and send you information that you have request or consented to us sending.  If we believe that you are at serious risk of harm, abuse or neglect and this falls within adult safeguarding legislation, we may use your personal details to refer you to the adult safeguarding team in your local area. Wherever possible we will seek your consent to do this, however if we believe that this will put you or another person at an increased risk of harm then we may contact the adult safeguarding team or call the emergency services without your consent.  Information is only shared within Action for M.E. on a need to know basis. In order to provide effective Healthcare Services, we may share your information within the Action for M.E. Healthcare Services clinical team.We may need to liaise with your GP and other healthcare agencies. We will only do this with your consent.  **Declaration of consent**   * I give permission for Action for M.E. to process my personal data in order to provide a service to me. * I understand that no action will take place without my knowledge and consent and all information will be treated as confidential unless there is evidence or reasonable cause to believe I or another person is at risk of harm, abuse or neglect or if a crime has taken place/will occur. * Only information that is relevant to your healthcare will be recorded and securely stored as an electronic file. I understand that if I agree to my information being shared I have the right to limit how much is shared or to withdraw my agreement at any time.   **Declaration of third party consent (if applicable):**   * I give permission for the person/s named in section C to communicate with the Healthcare Services team on my behalf. | | | | |
| Your signature: | | | | Date: |
| **Section C: (only applicable if you are completing this form**  **on behalf of the person to receive Healthcare Services)** | | | | |
| Your name:  Your relationship to person in section A (eg. parent, spouse):  Your email:  Your telephone number:  **Data Protection**   * You can find further information about how we process and use your data by reading our Privacy Policy, available online at [www.actionforme.org.uk/privacy](http://www.actionforme.org.uk/privacy) or we can send you a copy by post. * We will use your email/telephone number to keep in contact with you.   **Declaration of consent**   * I give permission for Action for M.E. to process my personal data in order to provide a service.   Your signature:  Date: | | | | |
| **Section D (only applicable if you are applying for a bursary for this service):** | | | | |
| **If you have been awarded a financially assessed benefit, and the money is available in the Bursary Fund, you will be eligible for bursary support. If you are not in receipt of benefits, you may still be awarded a bursary after a confidential discussion of your individual financial situation with a member of our team.**  **You will receive confirmation of your award by email. Your bursary allocation is valid for 12 months from the date of the confirmation email. Any sessions remaining at the end of this period will not be carried forward.**  **Further bursary support may be available if your financial circumstances are unchanged and after consultation with the appropriate member of the Action for M.E. Healthcare Services team.  (If you are completing this section on behalf of the person to receive Healthcare Services, this applies to the benefits *they* receive.)** | | | | |
| Please indicate which of the following benefits you receive from the list below.  Please tick all that apply  Income Support  Universal Credit  Jobseekers Allowance  Employment Support Allowance  Housing Benefit  Working Tax Credit  If you receive none of the benefits listed above, please give brief details of your financial situation and reasons why we might consider you for bursary support.  Which Action for M.E. Healthcare Service are you seeking bursary support for?  Please tick all that apply.  Doctor  Physiotherapist  Counselling  Chaplaincy | | | | |
| **Please return this form by email to** [**healthcareadmin@actionforme.org.uk**](mailto:healthcareadmin@actionforme.org.uk)  **Or by post to Action for M.E., 42 Temple Street, Keynsham BS31 1EH.**  **If you have any questions, please contact the team on 0117 927 9551.** | | | | |