

December 2010

MERSEYSIDE ASBESTOS VICTIMS SUPPORT GROUP

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Charity Reg. No. 1033724.

ASBESTOS RELATED DISEASE

PATIENT REFERRAL FORM

Today's Date.....

I.....the patient, hereby give permission to

Dr/Nurse.....to disclose and forward this referral

form to the Merseyside Asbestos Victim Support Group for welfare and benefits advice.

Signed.....Date.....

PATIENT DETAILS (BLOCK CAPITALS)

Forename.....

Surname.....

Address.....

.....

.....

Post Code.....

Tel.....

Date of Birth.....

Diagnosis.....

Date of Diagnosis.....

(Please Tick as appropriate)	
<u>PLEURAL PLAQUES</u>	<input type="checkbox"/>
<u>PLEURAL THICKENING</u>	<input type="checkbox"/>
<u>P.T of COST OPHRENIC ANGLE</u>	<input type="checkbox"/>
<u>ASBESTOSIS</u>	<input type="checkbox"/>
<u>LUNG CANCER /ASBESTOSIS</u>	<input type="checkbox"/>
<u>LUNG CANCER/P.THICKENING</u>	<input type="checkbox"/>
<u>LUNG CANCER/P.PLAQUES</u>	<input type="checkbox"/>
<u>BENIGN PLEURAL EFFUSION</u>	<input type="checkbox"/>
<u>MESOTHELIOMA (CONFIRMED)</u>	<input type="checkbox"/>
<u>MESOTHELIOMA (SUSPECTED)</u>	<input type="checkbox"/>
<u>ATTENDANCE ALLOWANCE APPLIED FOR?</u>	YES <input type="checkbox"/> NO <input type="checkbox"/>