|  |  |  |
| --- | --- | --- |
|  **Memory Tree Logo 2** | Date Received: |  |
|  | Consent Provided:**Date of 1st Visit:** |  |
| dementia Memory Tree café referRal form |
| All questions contained in this questionnaire are strictly confidential **\* ESSENTIAL INFORMATION****Please send completed referrals to:** **memorytreecafe@ageukcroydon.org.uk** |
| Name:\* |  | [ ]  M [ ]  F | DOB:\* |       |
| Marital status: | [ ]  Single [ ]  Partnered [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed  |
| Ethnicity: |  **Name of referrer:\*** |
| **Address** | Telephone:\* ………………………………………………. Mobile:…………………………………………………Email: …………………………………………………….. |
|  |
| PERSONAL HEALTH HISTORY |
| Illnesses: | 🞎Dementia 🞎 Memory Loss 🞎 COPD 🞎 Diabetes 🞎 Osteoarthritis 🞎 Heart Disease 🞎 Parkinsons🞎 Other …………………………………………………………………..Brief description of current impact of memory loss or dementia on daily activities: ………………………………………………….…… |
| Mobility: | [ ]  In wheelchair |       | [ ]  Rollator |       |
|  | [ ]  Sticks or frames |       | [ ]  Other |       |
|  |
| GP Surgery:\* |

|  |  |  |
| --- | --- | --- |
|  | Carers / NOK Contact Details\* |  |
| Name:  |  | [ ] M [ ]  F | Relationship to Client: |  |
| Telephone:………………………………………………… Mobile:……………………………………………………………………Email:……………………………………………………………. |

|  |
| --- |
| HEALTH HABITS AND PERSONAL SAFETY |
| Personal Safety | Do you live alone? | [ ]  | Yes | [ ]  | No |
| Do you have frequent falls? | [ ]  | Yes | [ ]  | No |
| Do you have vision or hearing loss? | [ ]  | Yes | [ ]  | No |
| Do you feel depressed? | [ ]  | Yes | [ ]  | No |
| Do you panic when stressed? | [ ]  | Yes | [ ]  | No |

**I or my carer, give my consent and permit Age UK Croydon to record personal information about myself in accordance with Age UK Croydon’s Safeguarding Adults and Confidentiality Policies** (I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn).

For carer; I understand that staff running the Memory Tree Café are NOT carers and CANNOT undertake caring duties or be held responsible for anybody’s personal care, safety or whereabouts.

For carer; I understand if the person I care for/am responsible for (named above) is not independent enough, they should be accompanied by myself or someone else who can be responsible for them.

Name of Client (print clearly): ……………………………………………………………………………………………………………………………

Signature: ……………………………………………………………………………………………….………. Date: ………………………………………

Name of Carer (print clearly): ……………………………………………………………………………………………………………………………

Signature: ………………………………………………………………………………………………………. Date: ………………………………………

**Pre-activity readiness health questionnaire – Memory Tree Cafe**

For most people, physical activity does not pose a hazard, however, you are advised to consult your doctor before undertaking any physical activities.

1. Are you accustomed to physical exercise? Yes No
2. Has your doctor ever said you have a heart condition? Yes No
3. Do you feel pain in your chest or legs when you do physical activity? Yes No
4. Do you ever lose balance because of dizziness or ever lose consciousness? Yes No
5. Do you have uncontrolled high/low blood pressure? Yes No
6. Do you have a bone or joint problem such as arthritis that could be made worse by a change in your physical activity? Yes No
7. Is there a physical reason not mentioned here, or has a doctor ever advised that you should not follow an activity programme? Yes No

Any other health/medical conditions

Medication prescribed.

Do you have a disability?

GP Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Details:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Declaration**

I understand that if I have answered ‘Yes’ to one or more of the above medical questions, or have any unstable condition not controlled with medication, I should seek medical advice before attending an activity programme. I do not wish to do so at present. I agree to inform AUKC if there is a change in my medical condition. I understand that this information will be shared with other activity leaders, but will be kept confidential from third parties, and I take part in the activity at my own risk. I am fully aware of the risks involved; I understand I am responsible for my own safety.

Signature…………………………………………………………………Date………………...

**Or**

Carers Signature (on behalf of client)……………………………………… Date……………