**Dementia Service Referral**

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| **Completed by:** |  | | | **Date:** |  |
| **Referral made by *(please circle):*** | **Self** | **Family** | **Organisation *(please state name)*:** | | |

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| **PERSONAL INFORMATION** | | | |
| **Surname:** |  | **First name:** |  |
| **Initial:** |  | **Title:** |  |
| **Address:** |  | | |
|  |  | | |
| **Town:** |  | **Postcode:** |  |
| **Main telephone number:** |  | **Mobile:** |  |
| **Gender:** |  | **Date of birth:** |  |
| **Age:** |  | **Ethnicity:** |  |
| **Religion or belief:** |  | **Employment status:** |  |
| **Number in household:** |  | **Who lives with you?:** |  |

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| **HEALTH AND WELL BEING** | | | |
| **GP Practice:** |  | | |
| **GP Name:** |  | | |
| **Are you registered disabled? *(please circle)*:** | **Yes** | **No** | **If yes, please give further details below:** |
|  | | | |

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| **Please detail any risk issues that we need to be aware of (including any history of violence or aggression):** | | |
| **Please detail any daily support needs due to the dementia/memory loss diagnosis:** | | |
| **Details of regular medications (if applicable):** | | |
| **Have you been in hospital as an in-patient in the last month? *(please circle)*:** | **Yes** | **No** |

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| **NEXT OF KIN / EMERGENCY CONTACT DETAILS** | |
| **Name:** |  |
| **Telephone / Mobile:** |  |
| **Address:** |  |
| **Relationship:** |  |

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| **REASON FOR REFERRAL** |
| **What help does the person need from the Dementia Support Service? (MCST Group, Buddy Support, Carers Course, Dementia Advice):** |