**Dementia Wellbeing & Befriending Referral Form**

**Please email or post the completed referral form to the Dementia Wellbeing Lead at:** [**dementia.wellbeing@ageukcamden.org.uk**](mailto:dementia.wellbeing@ageukcamden.org.uk)

Henderson Court Health & Positive Living Hub, 102 Fitzjohns Avenue, London, NW3 6NS

T0208 103 3991

|  |  |  |  |
| --- | --- | --- | --- |
| **Referral Criteria:**   * Aged 55+ * Lives in Camden * Is diagnosed with mild cognitive impairment/early stages of dementia * Meets one of the following service-specific criteria (tick the boxes) | | | |
| **Befriending:**   * Lives alone * Is housebound * Has limited to no support network (family/friends) * Not engaged with other social or community services (e.g., resource or day centers, lunch clubs) |  | **Wellbeing:**   * Lives alone * Is housebound * Has limited to no support network (family/friends) |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **\*Please feel free to contact the service to discuss any further referrals\*** | | | |

**Personal Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title: |  | Gender: |  | Tel: |  |
| Full name: |  | | | Address: |  |
| Date of Birth: | 09/02/1968 | | |

**Next of Kin**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title: |  | Are you a carer? | Yes/No | Tel: |  |
| Full name: |  | | | Address: |  |
| Date of Birth: |  | | |

**GP details (if known)**

|  |  |
| --- | --- |
| Name: | Health needs/Medical Conditions:  Details of mobility and support required: |
| Practice name and contact details: |

**Essential**

**Risk Assessment/Further Information – *circle either yes or no***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the person know they are being referred? | | Yes/No | Drug/Alcohol issues | Yes/No |
| Can they be contacted by telephone? | | Yes/No | Violence/Aggression | Yes/No |
| State if any pets: | | Yes/No | Abuse from others | Yes/No |
| Self-Neglect | | Yes/No | Environmental hazards | Yes/No |
| Self-Harm | Accidental | Yes/No | Other risk factors: | |
| Intentional | Yes/No |

**Isolation Indicators- *circle either yes or no***

|  |  |  |
| --- | --- | --- |
| Family visits | Yes/No | Does the person receive any other support/services? (Including referrals) |
| Friends/neighbors visits | Yes/No |
| Care services | Yes/No |
| Day center | Yes/No |
| Community center | Yes/No |
| Lunch club | Yes/No |
| **\*We aim to work closely with other agencies to ensure the best outcome for the person being referred. Please provide as much information as possible about support received from agencies, friends& family etc.\*** | | |

**Further information (Please comment)**

|  |
| --- |
| **Does the person have memory issues? Is the person diagnosed with mild cognitive impairment or dementia? (Specify diagnosis and stage if known)**  **Presenting problem: (repetitive speech, losing things, frustration, hallucinations, social withdrawal, loss of confidence)**  **Are there any sensory (visual or hearing) or communication/language difficulties? (e.g., word finding difficulties)** |

**Background information**

|  |
| --- |
| **Life history (including past occupations, interests/hobbies, relationship with family)**  **Personality** |

**Reasons for referral**

|  |  |
| --- | --- |
| **Dementia Befriending** | **Dementia Wellbeing** |
|  |  |

**Referrer’s Details**

|  |  |  |
| --- | --- | --- |
| Name: |  | Address: |
| Relationship/Occupation: |  |
| Email: |  |
| Tel: |  | Date: |