Keep in Mind Referral form

Please note, you must complete ALL highlighted sections on this referral form, or the referral will not be processed, and it will be returned to you for completion.

We do not accept referrals from areas that do not come under Doncaster Council. Such as, Harworth, Bircotes, Epworth etc.

Please email to: keepinmind@ageukdoncaster.org.uk

Date of referral:		**Name of Referrer:**	
Name of Agency / Self / Relationship to Person living with Dementia.		**Telephone Number:**	
How did you hear about Keep in Mind?		**Email address:**	

☐**Select for carer referral only. Please move onto the carer section.**

Details of person living with Dementia being referred:

Title:		**Name:**	
Date of Birth:		**NHS number if known:**	
Ethnicity		**Preferred Language:**	
Diagnosis of dementia and type:	**Yes/No** **Diagnosis type:** **Date of diagnosis:**	**Known to Mindset service?**	
Address including postcode:	1	**Contact details:**	**Tel:** Email:

Who do we contact regarding this referral?	☐Person living with Dementia ☐Next of Kin ☐Referrer ☐Other	**Details if different to next of Kin.**	**Name:** **Contact details:** **Relationship to client:**
Reason for referral, support required.		**Health conditions:**	
		Allergies:	
		Communication needs:	

Other contacts:

Next of Kin Name:		**Next of Kin Contact details:**	**Tel:**
Relationship to client:			**Email:**
Named G.P:		**G.P Address:**	**Tel:** **Email:**
Other Professionals involved:		**Contact details:**	**Tel:** **Email:**
			Tel:
			Email:

Risk Assessment:

Does the client live alone?	**Yes**	**No**	**If "No", who else lives in the home?**	
Do you know of any previous concerns regarding safety in the client's home? Please list below:				
N/A				
Is there a lone working risk?	**Yes**	**No**	**If "Yes" please explain why below:**	
Are there any cultural needs we should be aware of?	**Yes**	**No**	**If "Yes" please detail needs here:**	

Consent:

I confirm the person being referred has given consent for the referrer to share their information with the Keep in Mind Service so they can be contacted.	**Yes/No**	**Name:** **Date:**
I confirm the person being referred has given consent for Age UK Doncaster to share their information with the Keep in Mind partners to provide services and support.	**Yes/No**	**Name:** **Date:**

Carer referral only

Title:		**Name:**	
Date of Birth:		**Ethnicity**	
Address including postcode:		**Contact details:**	**Tel:** **Email:**
Reason for referral:		**Health conditions:**	
		Allergies:	
		Communication needs:	

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