

**Dementia Services, Parker Centre, 6 Houndsfield Road, Edmonton, Enfield N9 7RA Tel: 0208 351 1131 FAX: 020 8375 4138**

**FALLS PREVENTION AND MEMORY CARE SERVICE**

**REFERRAL FORM**

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| **Client Name :** | |
| Address:  Postcode: | Telephone:  Email: |
| Reason for referral **Falls Prevention**   **Memory Care Service**  Has the client had a fall in the last 6 weeks: Yes  No  Has the client been referred to the falls clinic Yes  No  Has the client been diagnosed with dementia Yes  No  Has the client been referred to the memory clinic Yes  No | |
| **Background monitoring.**  Ethnic Background: please circle  White Asian/Asian British  Mixed Black/British  Chinese  Other Ethnic group please specify:  --------------------------------------------------------------------  Religion: | **Background monitoring.**  Date of Birth:  Sex: Male or Female (Please circle)  Status: Married Single Widowed  Divorced/separated Civil Partner  Lives alone: Yes/No |

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| **PRIMARY CARER**  Name  Home Tel  Mobile  Email Address  Relationship with client  **Is this the person to contact? Yes/No** | **GP DETAILS**  Name  Surgery  Address  Telephone  Fax  Email |

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| **CONSENT TO SHARE INFORMATION** | |
| No referral should be sent without prior client/family consultation. Have you made the client / family aware of this referral? | Yes  No |
| Please details any risk factors that would need to be considered for our staff lone working with this patient: | |

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| Referrer’s Signature: | Date: |

Email this form to: [**fallsprevention@ageukenfield.org.uk**](mailto:fallsprevention@ageukenfield.org.uk) **or** [**memorycare@ageukenfield.org.uk**](mailto:memorycare@ageukenfield.org.uk)