

**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 circleWhite Asian/Asian BritishMixed Black/BritishChinese Other Ethnic group please specify:--------------------------------------------------------------------Religion: | **Background monitoring.**Date of Birth:Sex: Male or Female (Please circle)Status: Married Single WidowedDivorced/separated Civil PartnerLives 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 AddressTelephoneFaxEmail  |

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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** **or** **memorycare@ageukenfield.org.uk**