**REFERRAL FORM – DEMENTIA SUPPORT SERVICE**

**Please complete and return to: Thorncroft, 244 London Road, Leicester LE2 1RH**

**Tel: 0116 2237363 Email: Dementia.leics@nhs.net**

**REFERRER DETAILS:**

|  |  |
| --- | --- |
| **Name of Referrer:** | **Role:** |
| **Tel:** | **Email:** |
| **Address:** | |

**SERVICE USER DETAILS:**

|  |  |
| --- | --- |
| **Person Living** **with Dementia Details:** | **Carer Details:** |
|  | Relationship to Person Living with Dementia: |
| Mr/ Mrs/ Miss/ Ms/ Other | Mr/ Mrs/ Miss/ Ms/ Other |
| Full Name: | Full Name: |
| Male  Female  Other | Male  Female  Other |
| Date of Birth: | Date of Birth: |
| Address: | Address: |
| Email: | Email: |
| Telephone numbers: | Telephone numbers: |
| Preferred Language: | Preferred Language: |
| Specialist communication needs: | Specialist communication needs: |

**Initial contact should be made with: ☐ Person Living with Dementia ☐ Carer**

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| --- | --- |
| **Dementia diagnosis information** | |
| Date diagnosed: | Is the person living with dementia aware of the diagnosis?  Yes  No |
| Type of dementia: |

|  |
| --- |
| **Who is the support for?**  Person Living with Dementia  Carer  Both |
| **Best time of day to call:** |
| **Can we leave voicemail messages?**  Yes  No  Unknown |
| **Can letters be sent?**  Yes  No |
| **Are there any risk factors we should be aware of?**  YES (provide details below)  NO  **Details of risk factors:** |

**REASON FOR REFERRAL:**

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| **What support is required?** |

|  |  |
| --- | --- |
| **For Office Use Only** |  |
| Date referral received: | Allocation to: |
| Received by: |  |