**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: |

|  |
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| **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: |  |