**MEMORY ADVICE AND DEMENTIA SUPPORT SERVICE**

**REFERRAL FORM**

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

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

**CONSENT REQUIRED**

Before making this referral, you must obtain consent from the person you are referring. Please tick the boxes below to confirm that verbal consent has been obtained and they have consented to the Memory Advice & Dementia Support Service making contact with them:

**The person being referred has:**

Consented to being referred into the Memory Advice Service & Dementia Support Service

**Please confirm that the person has consented to being contacted by:**

Phone Email

SMS (Text) Post

**REFERRER DETAILS:**

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

**DETAILS OF PEOPLE BEING REFERRED:**

|  |  |
| --- | --- |
| **Person with memory difficulties or dementia:** | **Carer / Supporter:** |
|  | Relationship to Person Living with memory difficulties or 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 with memory difficulties or dementia ☐ Carer / Supporter

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| **Diagnosis information** |
| Is the person on the waiting list for the memory assessment service?  Yes  No |
| Has the person already been assessed by the memory assessment service?  Yes  No |
| Does the person have a diagnosis for their memory difficulties (such as Mild Cognitive Impairment or dementia)?  Yes  No |
| If the person has been diagnosed, what is the diagnosis? |
| Date of diagnosis |
| Is the person aware of their memory difficulties or dementia?  Yes  No |

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| **Who is the support for?**  Person with memory difficulties or dementia  Carer / Supporter  Both |
| **Best time of day to call:** |
| **Can we leave voicemail messages?**  Yes  No  Unknown |
| **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?** |