**Section 1:**

|  |  |
| --- | --- |
| Referral date:  |  |

The client must have given consent before making this referral. Is consent given? (Please tick)

**Please tick:**

|  |  |  |  |
| --- | --- | --- | --- |
| I am a professional referring into the MCST programme  |  | I am a person living with dementia or experiencing memory impairment |  |
| I am a friend/family member of a person living with dementia  |  | Other (please specify) |  |

**Section 2: Referrer details**

Please complete this section if you are referring someone else to the programme. This includes if you are referring a friend or family member. **If you are self-referring, skip to Section 3.**

|  |  |
| --- | --- |
| Name: |  |
| Relationship to the person that you are referring: |  |
| Organisation and job title: |  |
| Contact number: |  |
| Email address: |  |

**Section 3: Client’s details** (person with dementia or memory impairment)

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Telephone: |  |
| Gender: |  |
| Date of Birth: |  |
| **Next of Kin:** |
| Name: |  |
| Relationship to client: |  |
| Phone: |  |
| Address: |  |

|  |
| --- |
| Who would you like us to make the first contact with? Please tick:  You (the referrer) Client (Person with dementia or memory impairment)  Next of Kin Someone else e.g. a carer (please provide their details below) ………………………………………………………………………………………………… |

**Section 4: Dementia and other health conditions**

|  |  |
| --- | --- |
| Has dementia been diagnosed? | Yes / No |
| Who diagnosed the dementia? E.g. GP, hospital |  |
| Date the diagnosis was made: |  |
| Type of dementia: |  |
| Has a Cognitive Stimulation Therapy (CST) course been completed? | Yes / No |
| Location of CST course/date completed: |  |

**Please circle:**

|  |  |
| --- | --- |
| Mobility: | Independent Independent with mobility aid Restricted Assistance required   |
| Hearing: | Able to hear Hearing aid Limited Partially deaf Deaf  |
| Vision: | Good Visually Impaired Registered Blind |
| Speech: | Clear Slurred Limited Non-verbal |

|  |  |
| --- | --- |
| Other health conditions: | GP details: |

|  |
| --- |
| Is there any other information that you would like to share with us regarding this referral? |

**Section 5: Equality and Diversity Monitoring Form**

Age UK Wandsworth wants to meet the aims and commitments set out in its equality policy. This includes not discriminating under the Equality Act 2010 and building an accurate picture of the make-up of the service users in encouraging equality and diversity.

The organisation needs your help and co-operation to enable it to do this by filling in this form. Please endeavour to fill this it out as accurately as you can. The information provided will be kept confidentially and will be used for monitoring purposes.

**Gender:** Male ☐ Female ☐ Intersex ☐ Non-binary ☐ Prefer not to say ☐

 If you prefer to use your own gender identity, please state:

…………………………………………………………………………….

Is the gender you identify with the same as your gender registered at birth?

Yes ☐ No ☐ Prefer not to say ☐

**What is your ethnicity?**

Ethnic origin is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong. Please tick the appropriate box

***Asian or Asian British***

Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Prefer not to say ☐

Any other Asian background, please state:

***Black, African, Caribbean or Black British***

African ☐ Caribbean ☐ Black British ☐ Prefer not to say ☐

Any other Black, African, or Caribbean background, please state:

***Mixed or Multiple ethnic groups***

White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐

Prefer not to say ☐ Any other Mixed or Multiple ethnic background, please state:

***White***

English ☐ Welsh ☐ Scottish ☐ Northern Irish ☐ Irish ☐

British ☐ Gypsy or Irish Traveller ☐ Prefer not to say ☐

Any other White background, please state:

***Other ethnic group***

Arab ☐ Prefer not to say ☐ Any other ethnic group, please state:

**Do you consider yourself to have a disability or health condition?**

Yes  **☐** No ☐ Prefer not to say ☐

**What is your sexual orientation?**

Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Asexual ☐ Pansexual ☐ LGBTQ+ ☐ Prefer not to say ☐

If you prefer to use your own identity, please state:

…………………………………………………………………

**What is your religion or belief?**

No religion or belief ☐ Buddhist ☐ Christian ☐ Hindu ☐ Jewish ☐ Muslim ☐

Sikh ☐ Prefer not to say **☐** If other religion or belief, please state:

**Do you have caring responsibilities? Please tick all that apply:**

None ☐

Primary carer of a child/children (under 18) ☐

Primary carer of disabled child/children ☐

Primary carer of disabled adult (18 and over) ☐

Primary carer of older person ☐

Secondary carer (another person carries out the main caring role) ☐

Prefer not to say **☐**

**Section 6: Transportation**

Age UK Wandsworth is unable to provide transportation to and from the MCST sessions. Please tick the box below to confirm that you are able to make your own transportation arrangements.

Yes, I am able to arrange my own transportation to and from the Gwynneth Morgan Day Centre for the MCST sessions. ☐

**Section 7: Consent**

**Please read the information below and tick the box if you agree:**

I give my consent for Age UK Wandsworth to keep a written record of the information on this form. Consent to store my information can be withdrawn at any time by contacting 020 8877 9740 or info@ageukwandsworth.org.uk

|  |
| --- |
| Please return your completed form by email to daycentre@ageukwandsworth.org.uk or drop it off at Reception at the Gwynneth Morgan Day Centre, 52 East Hill, SW18 2HJ between 10am-3pm Monday-Friday. For more information on the MCST programme, or for help with filling out the form, please call Frank on **020 8812 3645** or email him at daycentre@ageukwandsworth.org.ukPlease see our website for further information on all of our services: [www.ageukwandsworth.org.uk](http://www.ageukwandsworth.org.uk) |