This referral form is for use by external organisations/agencies to refer people into Alzheimer’s Society services. Please always ensure that the person being referred (as detailed within the form) has consented to this referral.

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| Service being referred into: | South Glos Dementia Support |
| Service team email address: | [southgloucestershire@alzheimers.org.uk](mailto:southgloucestershire@alzheimers.org.uk)  Please include [secure] in subject line if sending from an NHS email address. For non-NHS services, please use your organisation’s secure email process. |

**Personal details of the person being referred**

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| Mr/Mrs/Miss/Ms/Other: | | | Person with Dementia  Carer |
| First name: Known as: | | | Male Female Self-described  Prefer not to say |
| Surname: | | |
| Date of Birth: | | |  |
| Address: | | | |
| Postcode: | Email: | | |
| Tel no: | | Mobile: | |

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| **Diagnosis Status** (only required where a person with dementia is being referred) | | |
| **Pre-Diagnosis:**  *(****eligible for: information provision****)* | Worried about their memory or awaiting diagnosis | |
| **Post-Diagnosis:**  *(****eligible for: dementia support****)* | Please give details below: | |
| Type of dementia: | | Who made it? (if known) |
| When was it made? | | Has the person diagnosed been informed of the diagnosis?  Yes  No If no please give reason below: |

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| **Communication Needs** | | |
| Preferred Language? |  | |
| Specialist Communication Needs?  e.g. BSL, Interpreter, Braille, Makaton |  | |
| Preferred Method/time of contact? |  | |
| Initial contact to be made to ‘**designated contact**’ (as detailed in the section below) | |  |

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| **Designated Contact details** | | | |
| By completing this section of the form, you are confirming that the person being referred has given their consent for communication with the Alzheimer’s Society to be conducted through the designated contact named below. | | | |
| Relationship to person being referred: | | | |
| Mr/Mrs/Miss/Ms/Other: | | Surname: | |
| First name: | | Known as: | |
| Address: | | Postcode: | |
| E-mail: | Tel: | | Mobile: |

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| **Risk**  Detail any potential risks to person being referred, our employees or volunteers if service is provided | | | | | | | | |
| Are there any known risks? Yes No Not known  (animal/s, pets, potential threat from household members etc.) | | | | | | | | |
| If Yes, please specify | | | | | | | | |
| Is a joint visit required? Yes No Not known | | | | | | | | |
| **Reason for referral?** (Describe as fully as possible) | | | | | | | | |
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| Information on dementia/support services | | | |  | | | To reduce social isolation |  |
| Information on legal decisions and benefits | | | |  | | | To engage in community life |  |
| To access health & social care services | | | |  | | | To prevent crisis |  |
| **Required Information** | | | | | | | | |
| **GP and surgery details:**  **Any other additional information:** | | | | | | | | |
| **Referrer’s contact details** (if not self-referral) | | | | | | | | |
| Mr/Mrs/Miss/Ms/Dr/Other: | | | | | | Job title: | | |
| First name: | | | | | | Surname: | | |
| Organisation Name: | | | | | | | | |
| Relationship to person being referred: | | | | | | | | |
| Address: | | | | | | | | |
| Postcode: | | E-mail: | | | | | | |
| Tel no: | | | | | Mobile: | | | |
| Date of referral: |  | |

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| Please tick this box to confirm the person being referred has been informed that their data will be passed to the Alzheimer’s Society in order for contact to be made regarding possible help and support that can be offered and that you have a record of their consent |

**Internal information:** Once the information recorded on this form has been transferred onto CRS, please dispose securely i.e., shred, confidential waste.