**Referral form**

This referral form is for use by external organisations/agencies to refer people into Alzheimer’s Society South Gloucestershire Dementia Support Service. 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 Gloucestershire Dementia Support** |
| **Service team email address:** | **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. |

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| **Person details** (Those of the person referred) | | |  |
| Mr/Mrs/Miss/Ms/Other: | | | Person with dementia or memory issues  Carer, Friend or Family Member |
| First name: | | | Male  Female  Non-Binary  ☐ Self-described  Prefer not to say |
| Known as: | | |
| Surname: | | | Date of birth: |
| Address: | | | |
|  | | | |
| Postcode: | E-mail: | | |
| Preferred Tel no: | | Alternative Tel no: | |

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| **Diagnosis Status** (only required where a person with dementia or memory issues is being referred) | | |
| **Pre-Diagnosis:**  *(eligible for: information provision)* | Worried about their memory | |
| Awaiting Memory Assessment/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 |

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| **Communication Needs** | | |
| Preferred Language? |  | |
| How well do they speak English?  (if Preferred Language is not English or Welsh) | Very Well  Well  Not well  Not well at all | |
| 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 person named below. | | | |
| Relationship to person being referred: | | | |
| Mr/Mrs/Miss/Ms/Other: | | Surname: | |
| First name: | | Known as: | |
| Address: | | | |
|  | | | |
| Postcode: | E-mail: | | |
| Preferred Tel no: | | | Alternative Tel no: |
| **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 | | | |

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| **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 |  |

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| **Additional Information** |
| **GP and surgery details:**  **Any other additional information:** |

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| **Referrer’s contact details** | | | |
| Mr/Mrs/Miss/Ms/Other: | | | Job title: |
| First name: | | | Surname: |
| Organisation Name: | | | |
| Relationship to person being referred: | | | |
| Address: | | | |
| Postcode: | E-mail: | | |
| Tel no: | | Mobile: | |

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| 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 for contact to be made regarding possible help and support that can be offered and that you have a record of their consent |

**Office use:** This document must be disposed of securely (shredded or placed into confidential waste) once details have been entered onto CRS.