**Referral form**

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**

|  |  |
| --- | --- |
| **Service being referred into:**  | **North Somerset dementia support**  |
| **Service team email address:** | Please send using your organisations encrypted secure email system to north.somerset@alzheimers.org.uk |

**Personal details of the person being referred**

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

|  |
| --- |
| **Diagnosis Status** (only required where a person with dementia is being referred) |
| Pre-Diagnosis:  | [ ] Worried about their memory or awaiting diagnosis **(only advice offered)** |
| **Post-Diagnosis:** | [ ] **Please give details below:** **do not leave blank**  |
| **Type** of dementia: | **Who** made it? (if known) |
| **When** was it made? | Has the person diagnosed been informed of the diagnosis? [ ]  Yes [ ]  No |

|  |
| --- |
| **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)  |[ ]

|  |
| --- |
| **Designated Carer Contact details (please complete fully)** |
| 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 no: | Mobile: |

|  |
| --- |
| **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? (Tick all that apply)** |
| Information on dementia/support services |[ ]  **Other, please specify:** |
| Information on legal decisions and benefits |[ ]   |
| To access health & social care services  |[ ]   |
| To reduce social isolation |[ ]   |
| To engage in community life |[ ]   |
| To prevent crisis |[ ]   |
|  **Required Information** |
| **GP and surgery details:****Any additional information to support this referral:** |

|  |
| --- |
| **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: |  |

|  |
| --- |
| 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.