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| **SECTION 1 – PATIENT DETAILS** |
| Full Name: |  | NHS No: |  |
| DOB: |  | Phone: |  |
| Gender: |  | Ethnicity: |  |
| Address & Postcode: |  |
| Contact details of significant other &relationship**REQUIRED PLEASE TO AVOID MISSED APPOINTMENTS** |  | Phone: |  |
| **SECTION 2 – REFERRER DETAILS (If you are not the GP they must be aware of referral being made)** |
| Referrer name & Contact Details |  |
| GP Surgery |  | Referral date: |  |
| Interpreter required? | Yes/No | First Language |  |
| Any other communication/sensory difficulties? |  |
| **SECTION 3 – CONSENT**  |
| Have you discussed this referral with the patient? Have they consented or, if they do not have capacity, are you proceeding in their Best Interests (BI)?Who should we arrange any appointments with, patient or significant other? |
| **SECTION 4 – SAFETY** |
| Does the person live alone? Any social care involvement?Current risks to patient:Potential risks to staff:Safeguarding concerns:Is there a history of alcohol or drug misuse? Current alcohol consumption in units per week?  Is the patient still driving? Yes/No/NAHave you discussed driving with the patient? Yes/NoAny details known re. driving ability:If there are concerns re driving ability what actions have you taken?   |
| **SECTION 5 – REASON FOR REFERRAL**  |
| **Why are you referring this Patient to the service (please highlight or delete)?*** **For Advice Only**

*OR** **Diagnosis**  *OR*
* **For Post-diagnostic Support & Advice**
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| ***For advice only:*** What advice is requested?Direct contact details please: |
| ***For Diagnosis:*** What is the history/duration of impairment?Impact on day to day functioning?What brief cognitive screening has been done? What score was achieved? Current or previous history of depression/mental health problems?Any recent significant life events e.g. loss, physical ill-health, environmental change?If you found difficulty achieving a diagnosis what were the issues that require our intervention/assessment?Has dementia been discussed as a potential diagnosis? |
| Date of blood screen (within last 3 months) |  | CT brain scan within the timeframe of symptoms (give date), or has one been requested? |  |
| ***Please attach Blood screen results*** ***(to include: FBC, U&E, TSH, LFT, Vitamin B12, Serum Folate, Bone Profile/Calcium, HbA1c), CT head results and Patient Summary*** |
| ***For Post-diagnostic Support & Advice:***What is the pre-existing diagnosis? (please state formal diagnosis):Has the pre-existing diagnosis of dementia been disclosed to the patient and family? (if ‘No’ please disclose before referring)**Please indicate what support is needed** **Further information to support this referral:***Please attach CT head results and Patient Summary* |

**Functional Changes:**Although it is sometimes difficult to measure functional change due to cognitive decline (rather than due to age, physical health conditions, mental health or sensory impairment), it is essential in the diagnosis of dementia.

The following questions are completely optional but maybe useful in uncovering evidence of functional change.

Does the individual have difficulty?

* Concentrating on tasks and/or returning to tasks following interruption or distraction
* Solving problems that occur within everyday situations
* Planning an activity (e.g. what time to leave to get to an appointment)
* Organising tasks or activities so that they complete things in a logical order and/or in time
* Completing tasks fully first time round (e.g. returning to the supermarket for forgotten items)
* Without prompts/aid memoirs than they use to be (e.g. shopping lists/”to do” lists, calendars)

 **Your referral may not be accepted if you have not considered diagnosis independently**