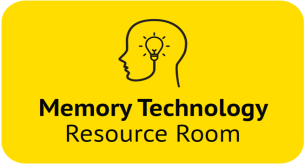
**Memory Technology Library**

**The Grounds of South Tipperary General Hospital,**

**Clonmel**

**0871090799 or 0526177080**

[](https://www.hse.ie/)**Memory** **Technology Resource Room**

**Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Complete Section 1 & 3** to refer a **CARER** or **FAMILY MEMBER** | | | | | | | | | | | |
| **SECTION 1: Consent Received Y** 🞎 **N** 🞎 | | | | | | | | | | | |
| Name of carer/ family member: | |  | | | | *Regarding the person with memory difficulties*, *please insert:*  Age: \_\_\_\_ **yrs** Gender:  **M** 🞎 **F** 🞎 | | | | | |
| Address: | |  | | | | Reason for referral to MTRR: | | | | | |
| Telephone no: | |  | | | | Relationship(to person with memory difficulties): | | | | | |
| **Complete Section 2 & 3** to refer a **PERSON WITH MEMORY DIFFICULTIES or DEMENTIA**  **only if** they have given their consent. In the absence of their consent, please complete Section 1 & 3 to refer a Carer. | | | | | | | | | | | |
| **SECTION 2: Consent Received Y 🞎 N 🞎** | | | | | | | | | | | |
| Name: | |  | | | | Contact  person’s name | | |  | | |
| Address: | |  | | | | Contact person’s relationship | | |  | | |
| Telephone No: | |  | | | | Contact person’s  telephone no | | |  | | |
| DOB: | |  | | | | GP Name & Address: | | |  | | |
| Age | |  | | | | Consultant name: | | |  | | |
| **Regarding the person with memory difficulties please comment on the following:** | | | | | | | | | | | |
| Lives Alone? **√** | | Yes | | No | | With whom/ Details? |  | | | | |
| **Services availed of at present if any:** **√** | | | | | | Homecare 🞎 | Day Centre 🞎 | | | Respite Care 🞎 | |
| **Other professionals involved *(Please list)* :** | | | | | | | | | | | |
| **Relevant Medical History of Person with memory difficulties:** | | | | | | | | | | | |
| **Diagnosis of Dementia:** Yes / NoDate of Diagnosis: Subtype if Known : | | | | | | | | | | | |
| **Reason for Referral:** | | | | | | | | | | | |
| **Other relevant information:**  **Cognitive assessment scores (*if available*)** | | | | | | | | | | | |
| **Assessment type**  *Folstein MMSE*  *MOCA* | **Score**  */30*  */30* | | **Date completed** | | **Assessment type**  *Addenbrooks Cognitive Evaluation III* | | | **Score**  */100* | | | **Date completed** |
| **SECTION 3: TO BE COMPLETED FOR ALL REFERRALS** | | | | | | | | | | | |
| **Referred by*:(print name)*** | | | | | **Discipline:** | | | | | | |
| **Address:** | | | | | **Email:** | | | | | | |
| **Date:** | | | | | | |
| **Signature:** | | | | | | | | | | | |