**Memory Technology Library**

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

**Clonmel**

**0871090799 or 0526177080**

**Memory** **Technology Resource Room**

**Referral Form**

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