**Referral Form**

**Name**: .............................................................................................................………………………**Date:** ........../............/.............

**Address:** ............................................................................................................................................................................................

**D.O.B**: ...............................................................................**Phone No:** ..........................................................................................

**Preferred Contact No**: ...............................................................................................................................................................

**GP Name & Address**: .................................................................................................................................................................

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| **When/Where was client diagnosed with dementia?**  **Subtype if known:**  **Is the client aware of their diagnosis? YES □ NO □**  **MMSE Score: ACE-R Score:** |

**Relevant Medical History:** .......................................................................................................................................................

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**Relevant Social History:** ........................................................................................................................

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**Any Other Relevant Information/Issue of Concern** ……………………………………………………….

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| **SERVICE REQUESTED** |
| **Information/Advice/Signposting** □  **Memory Technology Library/OT** □  **Dementia Nurse Specialist** □ **Dementia Support Worker** □    **Memory Rehab Programme** (*6 week programme* *for people diagnosed with early/mild dementia* □ (family member attendance recommended also) *to provide relevant information & practical strategies to support independence)*  **Psycho-education Programme** (*5 week programme* *for people with moderate dementia whose* □ *cognitive difficulties are more pronounced – family member/carer must be available to attend also)*  **Carer Education:** □  **Referred by** (Signature/Profession): |
| |  | | --- | | **For Office Use Only (referral management and outcome)** | | **Date Referral received:**  **Action Taken:** | | **Notes:** |  |  | | --- | | **IMPORTANT NOTE RE MEMORY REHAB & PSYCHOEDUCATION PROGRAMMES**  **CLIENT MUST BE:**   * **Aware of diagnosis** * **Available to attend full programme (in the Memory Technology Library Clonmel)** | |

**Please send by post to:**

**LIVING WELL WITH DEMENTIA SERVICE**

**MEMORY TECHNOLOGY LIBRARY, GROUNDS OF SOUTH TIPPERARY GENERAL HOSPITAL CLONMEL, CO. TIPPERARY**

**Tel No: 087-0550050 / 052-6177080**