**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): |
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| **For Office Use Only (referral management and outcome)** |
| **Date Referral received:****Action Taken:** |
| **Notes:**  |

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| **IMPORTANT NOTE RE MEMORY REHAB & PSYCHOEDUCATION PROGRAMMES** **CLIENT MUST BE:*** **Aware of diagnosis**
* **Available to attend full programme (in the Memory Technology Library Clonmel)**
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**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**