**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Personal Information** | | |
| **Name**: | **Date of Birth:** | |
| **Address**: | **Contact Number**:  **Name, relationship & number of other preferred contact:** | |
| **Name of GP:**  **Address of GP:** | | |
| **Diagnosis and Health Information** | | |
| **When/Where was client diagnosed with dementia?** | | **Subtype if known:** |
| **Is the client aware of their diagnosis? YES □ NO □**  Client must be aware of diagnosis to participate in Post Diagnostic Groups | | |
| **MMSE Score: ACE-R Score:** | | |
| **Relevant Medical History:**  ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… | | |
| **Relevant Social History:**  ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… | | |
| **Reason for Referral/Other Concerns or Relevant Information:**  ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… | | |

**PLEASE TURN OVER TO COMPLETE REFERRAL FORM**

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| **Services Requested** | |
| **Information/Advice/Signposting** **🞏** | **Dementia Nurse Specialist** **🞏** |
| **Memory Technology Library** **🞏** | **Dementia Support Worker** **🞏** |
| **Post Diagnosis Education Programme**:  *4 week programme* *for people diagnosed with early/mild dementia* *to provide relevant information & practical strategies to support independence.* **🞏** | |
| **Family Carer Dementia Education Programme:**  *4 week programme* *family carers of people living with dementia***🞏** | |
| **Referrer Details** | |
| **Signature of Referrer:** | **Profession:** |
| **Contact Number of Referrer:** | **Address of Referrer:** |

**Please Post referral to:** *The Living Well with Dementia Service, Memory Technology Library, The Grounds of Tipperary University Hospital, Western Road, Clonmel, Co. Tipperary Tel No; 087 0550050 /052 6177080*

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| **For Office Use Only** |
| **Action Taken:** |