**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:**  |