Logo

Description automatically generated

BME Dementia Referral Form

|  |  |  |
| --- | --- | --- |
| **Is this referral for a Carer or a PWD?** | Carer / PWD / Both | Office Use only  Date received:  Date added to the system: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrers details** | Name:  Organisation:  Contact details: | **Referral source** | GP  Health service  Social Care  Self  3rd Sector Org.  Police  Carer  Family  School  Probation  Other (Please specify) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PWD Details (Please fill in full if support is required)** | | | | |  |
| **Diagnosis:** | | | **Date of Diagnosis:** | |
| **Surname:** | **Forename:** | | | **DOB:** | **Gender:** |
| **Relationship status:** | | **Residency status:** | | | |
| **Tel:** | | **In Perm Care? Yes / no**  **Lives Alone? Yes / no** | | | |
| **Address:** | | | | **Postcode:** |
| **Email Address:** | | | |
| **Religion:** | **Sexual Orientation:** | | | **Ethnicity & First Language:** | |
| **GP:** | **GP Address & Tel:** | | | **Is PWD aware of diagnosis?** |
| **Consultant:** | **CPN/Memory:** | | |
| **Dementia Medication?** | **Social Worker:** | | |
| **Does the PWD consider themselves disabled?**  **Yes / no** | **Does the PWD have Autism?**  **Yes / no** | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Carers Details (Please fill in full if support is required)** | | | | |  | | |
| **Surname:** | | **Forename:** | | **DOB:** | **Gender:** | | |
| **Relationship status:** | **Residency status:** | | | | | | |
| **Tel:** | **Relationship to PWD:** | | | | | | |
| **Address:** | | | | **Postcode:** | | |
| **Email address:** | | | |
| **Religion:** | | **Sexual Orientation:** | | **Ethnicity and First Language:** | | | |
| **GP:** | | **GP Address & Tel:** | |
| **Any health problems for carer?** | | | |
| **Does the Carer consider themselves disabled or hold a blue badge?**  **Yes / No** | | **Lasting power of Attorney?**  **Yes / No** | | | |
| **Does the Carer have Autism?**  **Yes / No** | | |

|  |
| --- |
| Reason for Referral: |
|  |

**Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Carer’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referrers Signature:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please return this form to:**

[**bmedementia@touchstonesupport.org.uk**](mailto:bmedementia@touchstonesupport.org.uk)