Person ID | Name: | Date of Birth

Referral form

Self referral ☐
Referral by family member/friend ☐
Referral by health/social care organisation ☐
Referral by other service provider ☐

If self referral, how did the person hear of the Society?

_____

Referrer's details (if not self referral)

Name | Job title

Agency and address

Postcode | Tel no

Date of referral:

Personal details of the person being referred

Full name	Mr/Mrs/Miss/Ms/Other
Known as	☐ Male ☐ Female ☐ Transgender
Date of birth	Age
Address (permanent/temporary)	
Postcode:	**Tel no:**
Mobile:	
E-mail:	
Cultural/ethnic origin (ask the person/family)	
First language:	
Marital Status Single ☐ Married ☐ Civil partnership ☐ Widowed ☐ Divorced ☐ Separated ☐	
Does the person live alone? Yes ☐ No ☐ What type of accommodation (own home, sheltered housing etc)?_____	
Diagnosis of dementia	
What is it?	Who made it?
When was it made?	Does person know the diagnosis? ☐ Yes ☐ No

Please return by email: darlingtonteesvalley@alzheimers.org.uk via your organisation's secure email.
Post: Alzheimer's Society, Tees Valley Hambleton & Richmondshire, Garget Walker House, 25A Olav Road, Richmond North Yorkshire, DL10 4PU. Telephone: 01748 825817.

Person ID | Name: | Date of Birth

Outline of service requested-

Specialist communication needs and preferred method of communication

Main Contact

Full name | Mr/Mrs/Miss/Ms/Other

Address

Postcode | Date of Birth

Tel no (home) | (work)

Mobile: | E-mail:

Relationship to person

Keyholder ☐ Yes ☐ No ☐ N/A | Lasting power of attorney ☐ Yes ☐ No ☐ N/A

Next Contact

Full name	Mr/Mrs/Miss/Ms/Other
Address	
Postcode	
Tel no (home)	Mobile:
Relationship to person	Keyholder ☐ Yes ☐ No

Other key holders (if applicable, ie: warden, neighbour), please give name and contact details:

GP details

Name	Tel no
Address	
	Post code

Consultants details

Name	Tel no
Address	
	Post code

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Person ID | Name: | Date of Birth

Details of any health issues (e.g. other medical conditions or disabilities)

Are there factors which need to be considered prior to assessment?
(animal, pets, potential threat from household members etc)

Is more than one person required to undertake assessment? (risk to personal safety?)

Other agencies involved in care/support (Community alarm, meals on wheels, district nurse)

CPN/Care manager/Social worker contact details

Out of hours emergency social services contact number

Does the person with dementia know that they are being referred to the Alzheimer's Society?

☐ Yes ☐ No

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Person ID [ ] Name: Date of Birth

_____

Internal use only:

Date person contacted:_____

Service requested	Y/N	Action/outcomes (i.e. initial assessment)
Home support		
Registered home care		
Day support		
DSW		
DA		
Peer support		
Dementia Cafe		
Advocacy		
Befriending		
Other (state)		

Additional comments on service(s) requested

Completed by: (Alzheimer's Society member of staff/volunteer):

Name:_____Signature_____ Date_____

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