All information provided will be treated according to the Alzheimer Society of Ireland Confidentiality Policy

Service User Name: D.O.B: Area:

Referral Form: Home Care ☐ Day Care ☐ Other Service ☐ **Date:**

Name: Address: Telephone: Date of Birth: Medical Card Number: Is the above named person aware of their diagnosis or has the persons diagnosis been disclosed to them? (Optional): Is the above named person a ward of court? Y/N ☐ (Optional): Is there an 'Enduring Power of Attorney' in place? Y/N ☐
Name of person making the referral: Address: Land-line: Mobile: Email: Relationship to service user: Reason for referral: *Signature:* *Date:*
Primary Carer: Address: Relationship to service user: Land-line: Mobile: Email:
Next of Kin: Address: Land-line: Mobile: Email:
Emergency contact details: Name: Name: Address: Address: Tel: Tel:

Service User Name: D.O.B: Area:

Public Health Nurse:

Address:

Email: Fax:

Land line: Mobile:

Other services: (Please note that other service involvement does not affect your application)

Day Centre: Yes ☐ No ☐

Day's:

Organisation:

Date service commenced:

Home Care: Yes ☐ No ☐

Day's:

Organisation:

Date service commenced:

Respite: Yes ☐ No ☐

Name of provider:

How often:

Physiotherapy: Yes ☐ No ☐

How often:

Occupational Therapy: Yes ☐ No ☐

How often:

Meals on Wheels: Yes ☐ No ☐

How often:

Assessment by specialised dementia services? E.g. Geriatrician, Psychiatry of Old Age Team, Memory Clinic? Please specify and give contact details:----------
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Service User Name: D.O.B: Area:

GP REPORT: Page 1 of 2

(A GP report must be provided. GP reports not completed in full will delay services commencing)

Name of GP:
Address:
Email: Fax:
Land line: Mobile:

Medical report for:

When was service user diagnosed: (DD/MM/YYYY):

How often does service user attend GP:

Type of dementia service user diagnosed with:

☐ Alzheimer Disease ☐ Vascular Dementia ☐ Other, Please specify_____

☐ Lewy body Dementia ☐ Korsakoff's Disease _____

☐ Fronto-temporal Dementia _____

Is the service user currently being treated for any other medical conditions: (Please specify)
Medication details: (Please document current prescribed medication, list any high alert medication). If appropriate please provide a prescription.

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Service User Name: D.O.B: Area:

GP REPORT: Page 2 of 2

(A GP report must be provided. GP reports not completed in full will delay services commencing)

Past Medical History:
Any Known Allergies?

Observations: Please include any mobility, personal care and behaviour observations

Additional Information: Please attach extra sheets as required.

I wish to refer the above named for dementia specific services provided by the Alzheimer Society of Ireland.

GP Printed Name GP Signature Date

_____ _____ _____

Please return completed referral form to: __ Click here to enter text.**_____**

_____

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Service User Name: D.O.B: Area:

FOR OFFICE USE ONLY

Date referral received: ***Home Care Co-ordinator Signature:*** **Referral noted in log book/template:** **Yes** ☐ **No** ☐	Date referral acknowledged to referee:
Date set for assessment:	PHN informed: Yes ☐ No ☐ Date:

Additional Notes (if required):

_____
_____
_____
_____
_____
_____

Information given on additional services within area (Please tick where appropriate):

Social Club ☐ Support Group ☐ Drop in Centre ☐ Other Home Care Service ☐

Family Carer Training ☐ Respite ☐ Telecare Package ☐ Helpline ☐

Additional Notes (if referral/information given on additional ASI services or external services):

_____
_____
_____
_____
_____