**REFERRAL FORM: Insert √ to select Day Care ◯ Home Care ◯ Respite ◯**

**A GP Report Form is attached, which should be completed by your GP.**

## Referral details:

Service user Name:

Address:

Telephone:

Date of Birth: Medical Card Number:

Is the above named person aware of their diagnosis of Dementia?

**Name of person making the referral:**

Address:

Land-line: Mobile: Email:

Relationship to service user:

Reason for referral:

| **Primary Carer:**<br>Address:<br><br>Relationship to service user:<br><br>Mobile:<br>Tel:<br>Email: | **Contact in Case of Emergency:**<br>Address:<br><br>Relationship to service user:<br><br>Mobile:<br>Tel:<br>Email: |
|---|---|
| **Other emergency contacts:**<br>Name:<br>Relationship to service user:<br>Address:<br><br>Tel: | <br>Name:<br>Relationship to service user:<br>Address:<br><br>Tel: |

| | |
|---|---|
| **Public Health Nurse:**<br>Address:<br><br>Email:<br>Fax:<br>Land line:<br>Mobile:<br>CSARS Attached: Yes ☐ No ☐ | **GP:**<br>Address:<br><br>Email:<br>Fax:<br>Land line:<br>Mobile: |

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

| | |
|---|---|
| Day Centre: Yes ☐ No ☐<br>Day's:<br><br>Organisation:<br><br>Date service commenced: | Home Care: Yes ☐ No ☐<br>Day's:<br><br>Organisation:<br><br>Date service commenced: |
| Respite: Yes ☐ No ☐<br>Name of provider<br><br>How often: | Occupational Therapy: Yes ☐ No ☐<br>How often: |
| Physiotherapy: Yes ☐ No ☐<br>How often: | Speech and Language Therapist (SLT)<br>Yes ☐ No ☐<br><br>If there is a SLT care plan in place obtain a copy.<br>NOTE: |
| Assessment by specialised dementia services? E.g. Geriatrician, Psychiatry of Old Age Team, Memory Clinic? Please specify and give contact details: | |

**GP REPORT REQUIRED: ASI will not be able to commence your service until a completed report from your GP is received. You should ask your GP to provide a report and list of your medications (on Kardex attached if appropriate). Please see over for a GP Report form and Medication Kardex. When sending the GP report form to the GP please insert the name of the person the GP report is for at the top of the GP report form (next page).**

**Data Sharing with the Alzheimer Society of Ireland (Services)**: ASI (registered charity – CHY No. 7868), provides non-acute community support services and receives H.S.E funding under Section 39 of the Health Act 2004. ASI processes the special category personal data of service users using the legal basis of Article Art.9.2.h GDPR and s. 52.1(d) & (e) of the Irish Data Protection Act 2019. In order to avail of the above legal basis an individual or organisation must meet the definition of "health practitioner" and "health service" as defined in s.2(1) of the Health Identifiers Act 2014. ASI meets these definitions and is permitted to share relevant data with other individuals or entities which also meet this threshold without the need for a written consent from the patient / service user. According to I.C.G.P guidelines, to provide patient care a doctor can avail of a number of legal basis: vital interests; the provision of health care; and public health. These guidelines advise that *only* disclosures of health data *unrelated* to the provision of medical or social care require a written consent from a patient. The I.C.G.P. guidelines, dated October 2018, can be accessed directly at http://www.icgp.ie/data. The ASI Data Protection Fair Processing Notice (Operations) can be accessed here : https://alzheimer.ie/wp-content/uploads/2019/01/Data-Protection-Fair-Processing-Notice-Operations-Jan-2019-1.pdf

THE ALZHEIMER SOCIETY of IRELAND

# GP REPORT FORM

## GP Report for (Insert name): _____

| |
|---|
| **Name of GP:** |
| **Address:** |
| **Email:** **Tel:** **Fax:** |

When was the patient diagnosed: (DD/MM/YYYY):

Is the service user a Ward of Court? Yes◯ No◯

Is there an Enduring Power of Attorney in place? Yes◯ No◯

How often does service user attend GP:

Type of dementia service user diagnosed with:

Alzheimer Disease ◯ Vascular Dementia◯ Other, Please specify_____

Lewy body Dementia◯ Fronto-temporal Dementia◯ _____

_____

| Past Medical History: |
|---|
| |
| |
| |
| |
| |
| |
| **Any Known Allergies:** |

**GP REPORT Continued (p2 of 2)**

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

**If a do not attempt to resuscitate order (DNAR) is in place GP to complete details:**

Having discussed future medical interventions with _____(service users name) and their family, a decision has been made that _____ (service users name) is not for CPR in the event of a cardiorespiratory arrest.

**GP Printed Name:** **GP Signature** **Date**

_____ _____ _____

**Additional Information: Please attach extra sheets as required.**

Copy of CSARS Attached (if available): Yes ◯ No◯

**GP Printed Name** **GP Signature** **Date**

_____ _____ _____

**Please return completed referral form to: ASI Day Care Centre Manager◯**
**ASI Day Home Care Coordinator◯ ASI Respite Centre Manager ASI Day Care Centre Manager◯**
**Name: _____ Email: _____**

**Address: _____**

**Tel/Mob: _____ Fax: _____**

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patient. The I.C.G.P. guidelines, dated October 2018, can be accessed directly at http://www.icgp.ie/data. The ASI Data Protection Fair Processing Notice (Operations) can be accessed here: https://alzheimer.ie/wp-content/uploads/2019/01/Data-Protection-Fair-Processing-Notice-Operations-Jan-2019-1.pdf

# GP Report Continued - Medication Kardex

THE ALZHEIMER SOCIETY of IRELAND

**ALLERGIES:**

**Type of reaction:**

**Name of Patient:**

**DOB: _____**

**GMS Number: _____**

## Regular Prescriptions

| | DATE TREATMENT STARTED | Approved Name of drug (Block Letters) | DOSE | ROUTE | SPECIAL INSTRUCTIONS | Time of administration: Indicate Prescribed times by tick | | | | | | | SIG PR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 08 00 | 12 00 | 13 00 | 15 00 | 180 0 | 21 00 | | |
| A | | | | | | | | | | | | | |
| B | | | | | | | | | | | | | |
| C | | | | | | | | | | | | | |
| D | | | | | | | | | | | | | |
| E | | | | | | | | | | | | | |
| F | | | | | | | | | | | | | |
| G | | | | | | | | | | | | | |
| **PRN MEDICATION** | | | | | | | | | | | | | |
| H | | | | | | | | | | | | | |
| I | | | | | | | | | | | | | |
| J | | | | | | | | | | | | | |
| K | | | | | | | | | | | | | |