# Dementia Navigator Support Referral form

### Referrer’s details:

|  |  |
| --- | --- |
| Name: | Job title: |
| Agency and address: | |
|  | |
| Postcode: | Tel no: |
| Date of referral: |  |

Has the person consented to the referral being made? Yes

No ☐

Does the person lack capacity? If so, is the referral made in their best interest? Yes ☐

No ☐

**Referral details:**

Person with a diagnosis of dementia ☐

Carer of a person with dementia ☐

Person with a memory problem, who does not yet have a diagnosis of dementia ☐

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full name:** | | | | **Mr/Mrs/Miss/Ms/Other** |
| **Known as:** | | | | **Male  Female  Other** |
| **Date of birth:** | | | | **NHS No:** |
| **Address (permanent):** | | | | |
| **Postcode:** | **Tel no:** | | | |
| **Mobile:** | **E-mail:** | | | |
| **Cultural/ethnic origin:** | | | **First language:** | |
| **Marital**  Single 🞏 Married 🞏 Civil partnership 🞏 Widowed 🞏 Divorced 🞏 Separated   **Status** | | | | |
| **Does the person live alone?** Yes 🞏 No 🞏  **Type of accommodation:** (own home, sheltered housing etc)? | | | | |
| **Diagnosis (*if referral is for a carer, please state the diagnosis of the person who is being cared for)*** | | | | |
| Does the person being referred have a diagnosis of dementia?  Yes  No  Not known ☐ | | Diagnosis made by:  Diagnosis details:  Date of diagnosis: | | |
| **If they do not have a diagnosis of dementia:**  Are they able to engage with the diagnostic service? Yes ☐ No ☐  Briefly describe any issues with accessing or engaging with diagnostic services: | | | | |

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| **Reason for Referral:** *Please mention any concerns regarding changes of behaviour, behavioural and psychological symptoms of dementia and risk factors* |

**Main Contact/ NOK**

|  |  |  |
| --- | --- | --- |
| **Full name:** | | **Mr/Mrs/Miss/Ms/Other** |
| **Address:** | | |
|  | | |
| **Postcode:** | | |
| **Tel no (home):** | **Mobile:** | |
| **Relationship:** | **Keyholder 🞏 Yes 🞏 No** | |

**Other contact / Keyholder:**

### GP details (required)

|  |  |
| --- | --- |
| Name: | Tel no: |
| Address: | |
|  | Post code: |

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

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| --- |
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### Details of medication:

### Other agencies involved in care/support (Community alarm, district nurse etc.):

|  |
| --- |
|  |

### CPN/Care manager/Social worker contact details:

|  |
| --- |
|  |

Please send this form to:

**Email: hackney@alzheimers.org.uk (please use an encrypted e-mail)**

**Post: Alzheimer’s Society, Unit 1, Ground Floor, 30 Felstead Street, Hackney Wick, E9 5LG**