# 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:  |

|  |
| --- |
| **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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| --- |
|  |

### 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**