**Referral form: Barnsley Dementia Support BTSDA Pilot**

This referral form is for use by external organisations/agencies to refer people into Alzheimer’s Society services. Please always ensure that the person being referred (as detailed within the form) has consented to this referral.

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| **Service being referred into:** | **Barnsley Dementia Support BTSDA Pilot** |
| **Service team email address:** | **barnsley-referrals@alzheimers.org.uk** |

**Personal details of the person being referred (only one person per form)**

|  |  |  |  |
| --- | --- | --- | --- |
| Mr/Mrs/Miss/Ms/Other: | | | Person being assessed  Carer |
| First name: | | | Male Female Self-described  Prefer not to say |
| Known as: | | |
| Surname: | | | Date of birth: |
| Address: | | | |
|  | | | |
| Postcode: | E-mail: | | |
| Tel no: | | Mobile: | |

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| **Diagnosis Status** (only required where a person being assessed is being referred) | |
| **Pre-Diagnosis:** | Awaiting dementia diagnosis |
| **MCI - Diagnosis** | Undergoing further assessment for dementia diagnosis |
| **Newly Diagnosed** | Date: Type: |

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| **Communication Needs** | | |
| Preferred Language? |  | |
| Specialist Communication Needs?  e.g. BSL, Interpreter, Braille, Makaton |  | |
| Preferred Method/time of contact? |  | |
| Initial contact to be made to ‘**designated contact**’ (as detailed in the section below) | |  |

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| **Designated Contact details if different from person being referred** | | | |
| By completing this section of the form, you are confirming that the person being referred has given their consent for communication with the Alzheimer’s Society to be conducted through the designated contact named below. | | | |
| Relationship to person being referred: | | | |
| Mr/Mrs/Miss/Ms/Other: | | | Surname: |
| First name: | | | Known as: |
| Address: | | | |
|  | | | |
| Postcode: | E-mail: | | |
| Tel no: | | Mobile: | |

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| **Additional Information, including any known risks useful to this referral** |
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| **Referrer’s contact details** | | | |
| Mr/Mrs/Miss/Ms/Other: | | | Job title: |
| First name: | | | Surname: |
| Organisation Name: | | | |
| Relationship to person being referred: | | | |
| Address: | | | |
| Postcode: | E-mail: | | |
| Tel no: | | Mobile: | |

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| Date of referral: |  |

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| Please tick this box to confirm the person being referred has been informed that their data will be passed to the Alzheimer’s Society in order for contact to be made regarding possible help and support that can be offered and that you have a record of their consent |

**Internal information:** Once the information recorded on this form has been transferred onto CRS, please dispose securely i.e., shred, confidential waste.