**Day Care Referral Form including GP Report**

**Day Care Referral Home Care Referral Respite Referral**

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| 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:**  Address:  Relationship to service user:  Land**-**line:  Mobile:  Email: | **Next of Kin:**  Address:  Relationship to service user:  Land**-**line:  Mobile:  Email: | | **Other emergency contacts:**  Name:  Relationship to service user:  Address:    Tel: | Name:  Relationship to service user:  Address:    Tel: | |
| |  |  | | --- | --- | | **Public Health Nurse:**  Address:  Email:  Fax:  Land line:  Mobile:  CSARS Attached: Yes No | **GP:**  Address:  Email:  Fax:  Land line:  Mobile: | |

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| **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: | | Physiotherapy: Yes No  How often: | | Occupational Therapy: Yes No  How often: | | Respite: Yes No  Name of provider  How often: | Assessment by specialised dementia services? E.g. Geriatrician, Psychiatry of Old Age Team, Memory Clinic? Please specify and give contact details: | | |

**Data Protection - Service user Consent Form**

We want to know about you so that we can give you the best service which meets your needs. We are obliged to comply with Data Protection legislation and we strive to ensure that we collect and use information fairly and for the purpose of benefitting the service user. We will keep all your information safe and private. Your primary information file will be in a locked filing cabinet in day care centre offices. Information we put on computer will be protected by a secure password. Some information on computer is stored securely outside the EU, but is stored in compliance with EU law.

Staff working with you directly, or their manager, will be able to see your detailed personal information. If you start to use another of our services, we will pass on your information so that you don’t have to answer all the questions again. We will not pass your information on to anyone else without your permission. The only exception is if we are required to do so by law or to protect you or someone else from serious harm.

You can ask to see the information we keep about you at any time. If you would like more information about our Data Protection Policy please ask the service manager for a copy of **The Alzheimer Society of Ireland, Service user Data and Information System and Acknowledgement Sheet.**

I consent to The Alzheimer Society of Ireland collecting, using and keeping my personal information to provide me with a service which meets my needs.

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR FAMILY MEMBER:** I explained the above information to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (S)he indicated they understood and were happy with this by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

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| **Medical report for:**  When was service user 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 Korsakoff’s Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fronto-temporal Dementia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Past Medical History: |
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| Any Known Allergies? |
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| **GP REPORT: Page 3 of 3** |  |  |  |  |  |  |  |  |  |  |  |  |

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

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| **Do Not Attempt Resuscitation Order**  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  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Additional Information: Please attach extra sheets as required.    CSARS Attached: Yes No |

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| 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:**

**Day Care Centre Manager:**

**Address:**

**Phone:**

**Email:**

**Fax**

**FOR OFFICE USE ONLY**

***Date referral received:***

**Referral noted in log book/template/salesforce: Yes No Date:**

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

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| Social Club Support Group Drop in Centre Other Home Care Service  Family Carer Training Respite Telecare Package/Assisted Devices Helpline |

**Date referral acknowledged to referee: \_\_\_\_\_\_\_\_\_\_\_\_**

**PHN informed: Yes No Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Initial Assessment:** **Date:\_\_\_\_\_\_\_\_\_\_\_\_ Planned date to attend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_**

Mobility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Continence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hobbies/interests:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mood/Personality:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other info required \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  | |  | | --- | | GP Report | | | | |  |  |  | |  | |  | | |  | | | |  | |  | | |  | | | |  | | | |  | |  | | | Allergies | | | | |  | | |  | | | | |
|  |  | | | |  |  |  | | **MEDICATION KARDEX** | | | |  | | | | |  | |  | | | |  | | | |  | | **Medical Card No:** | | | |  | | |  | |  | | |  | | | | |  | |
|  | **REGULAR PRESCRIPTIONS** | | | | | **Name:** | | |  | | |  | | |  | | | |  | |  | | | |  | | | |  | | |  | | | **Date of Birth** | | | | | | | | | |  | | |  |
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|  | **DATE** | | **Approved Name of drug (Block Letters)** | | | **DOSE** | | **ROUTE** | | **SPECIAL INSTRUCTIONS** | | **Time of administration indicate Prescribed times by tick** | | | | | | | | | | | | | | | | | | **SIGNATURE OF PRESCRIBER** | | | | | | | | | | **CANCELLED DATE** | | | | | |  | | | |
|  |  | | | | | | | | | | | **9** | | | | **12** | **13** | | | | | **17** | | | |  | | | |  | | | | | | | | | | | | | | | | | | |
| **A** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **B** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **C** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **D** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **E** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **F** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **G** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
|  |  | | | **PRN MEDICATION** | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **J** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **K** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **L** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |
| **M** |  | | |  | |  | |  |  | | |  | | | |  |  | | | | |  | | | |  | | | |  | | | | | | | | | |  | | |  | | | | | |