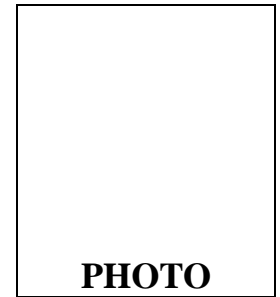




THE ALZHEIMER  
SOCIETY *of* IRELAND



**PHOTO**

**Form No:**

**REFERRAL FORM**

- HOME CARE   
DAY CARE   
RESPIRE

**Name of Person making the referral:**

Address:

Telephone:

Reason for Referral:

**Name of Client:**

Address:

Telephone:

Date of Birth:

GMS NO:

**Next of Kin:**

Address:

Telephone:

**Main Carer:**

Relationship to Client:

Address:

Telephone:

**Present condition of Client:**

**Name of GP:**

Address:

Telephone:

Fax:

email:

**Name of PHN or CPN:**

Address:

Telephone:

Fax:

email:

## **Family / Carers capacities to cope**

Can manage without help:

Need some help:

Need much help:

Unable to cope / no family / carer:

Willingness to continue caring:

## **Other Services Used:**

Day Centre – Day Hospital:

Home Help:

Health Care Assistant:

Respite:

Where and how often:

Home Support:

How often and who supplies service:

Community Nursing Services (PHN, RGN, CPN):

Physiotherapy:

Occupational Therapy:

Meals on Wheels:

Any other relevant service or voluntary organization involved in person's care:

## GP REPORT

Clients Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ GMS No: \_\_\_\_\_

Please give a detailed report on the above Client and also include an up to date prescription of all current medication.

Current vaccinations:

Known Allergies:

History of MRSA:	Yes	No
History of CDiff	Yes	No
Has had geriatric review	Yes	No
Name of geriatrician:	_____	
Has had physco geriatric review	Yes	No
Name of old age psychiatrist:	_____	

Medical history/ Surgical History:

Diagnosis of Dementia:

Date of Diagnosis

Diagnosis made by:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Please fill in the above form and return to:  
The Alzheimer Society  
Day/Respite Services  
Waterman's Lodge  
Ballina/Killaloe  
Co.Tipperary**

**PH: 061 374888**

**E-Mail Address: [clavelle@alzheimer.ie](mailto:clavelle@alzheimer.ie)**

**FOR OFFICE USE ONLY:**

Referral Date:	Acknowledged Date:
Service Commenced:	Review Date:

## **Annex 1**

### **Guidelines for General Practitioner's when completing the Medication Cardex and the Medical Report on the Referral Form**

Under the HIQA National Quality Standards it is a requirement of all registered nursing/respite facilities under medication management to have a clear legible medication cardex and GP report filled in and dated and signed by the client's GP.

Nursing staff cannot administer any form of medication to a client if they are not written up for it by their GP.

#### **When filling in the cardex and the GP report please:**

- Include ALL medical history on the GP report including hospital notes if applicable.
- Use printed lettering
- Please write instructions for all PRN Medications
- Sign signature opposite each medication
- Include date opposite each medication
- Include GMS number

If you have any queries about the Medical Report on the Referral Form or the Medication Cardex, please contact the respite centre at 01 2073838.

Thank you for your cooperation