CARiAD

Care And Respect In Advanced Dementia

Referral Form

Date of Referral:	Priority of referral: **[ ]Routine**(2-7 days) **[ ]Urgent**(24-48 hours)

Please note: All patient referrals may be telephoned or faxed

Type of referral:

Self-referral ❑ Referral by family member/friend ❑
Referral by health/social care organisation ❑ Referral by other service provider ❑
Telephone Referral ❑ Fax Referral ❑
(Tel. 01495 717277) (Fax: 01495 724188)

Referrer's details (if not self-referral)

Name Job title

Agency and address

Postcode Telephone number:

Reason for referral (This section must be completed);

REASON	TICK	EXPLAIN
Dementia Advice IS THE PATIENT REGISTERED WITH THE ALZHEIMERS SOCIETY? IS THERE ANY INFORMATION HOTV CAN SEND?		
Carers Support WHAT TYPE OF SUPPORT IS THE CARER REQUESTING? IS THERE A POC?		
Symptom Management WHAT ARE THE SYMPTOMS? HAS THE PATIENT BEEN PRESCRIBED ANY PAIN RELIEF?		
Palliative and End of life Care IS THE PATIENT EATING AND DRINKING? IS THERE A DNA CPR? IS THERE PRN`S IN THE HOME? DOES ANYONE HAVE POA?		
Other DAY CENTRE? WELFARE RIGHTS ADVICE? POA ADVICE? BEFRIENDING?		
IS THIS REFERRAL (PLEASE CIRCLE):		**URGENT** **ROUTINE**

Office use	ICARE:	Canisc:	CWS:	
	Person ID	Name:	DOB	

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Personal details of the person being referred

Full name	Mr/Mrs/Miss/Ms/other
Known as	❑Male ❑ Female
Date of birth	Age
Address	
Postcode	Tel no:
Mobile:	
E-mail	
Cultural/ethnic origin (ask the person/family)	
First language:	
Has this patient been in the services?	
Marital Status : Single ❑ Married❑ Civil partnership❑ Widowed ❑ Divorced ❑ separated ❑	
Social Situation (e.g. lives alone, whether mobile, problems with access, factors that need to be considered)	

GP Details

Name

Address

Post code

Telephone No.

GP aware of referral ❑ Yes ❑ No

Other professionals/care agencies patient known to (name and contact number where available):

❑ Hospital Consultant

❑ District Nurses

❑ Social Services

❑ Other:

Office use	ICARE:	Canisc:	CWS:	
	Person ID	Name:	DOB	

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Main Contact/Carer

Full name	Mr/Mrs/Miss/Ms/Other
Address	
	Postcode
Tel. No. (Home)	(Work)
Mobile	Email
Relationship to person	
Key holder ❑ Yes ❑ No	Lasting power of attorney ❑ Yes ❑ No

Diagnosis

What is it?	Who made it?
When was it made?	Does person know the diagnosis ❑ Yes ❑ No
Any other information	
Other medical diagnosis:	
Medication:	

Referral Acknowledged	Signed	Date

Office use	ICARE:	Canisc:	CWS:	
	Person ID	Name:	DOB	