Referral form

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.

Service being referred into:	**Dementia Support Stockport**
Service team email address:	**stockport@alzheimers.org.uk**

Personal details of the person being referred

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

Diagnosis Status (only required where a person with dementia is being referred)	
Pre-Diagnosis:	☐Worried about their memory or awaiting diagnosis
Post-Diagnosis:	☐Please give details below:
Type of dementia:	Who made it? (if known)
When was it made?	Has the person diagnosed been informed of the diagnosis? ☐ Yes ☐ No

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)		☐

Designated Contact details	
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:

Risk Detail any potential risks to person being referred, our employees or volunteers if service is provided
Are there any known risks? ☐Yes ☐No ☐Not known (animal/s, pets, potential threat from household members etc.)
If Yes, please specify
Is a joint visit required? ☐Yes ☐No ☐Not known

Reason for referral? (Tick all that apply)		
Information on dementia/support services	☐	**Other, please specify:**
Information on legal decisions and benefits	☐	
To access health & social care services	☐	
To reduce social isolation	☐	
To engage in community life	☐	
To prevent crisis	☐	
Additional Information		

Referrer's contact details (if not self-referral)		
Mr/Mrs/Miss/Ms/Other:		Job title:
First name:		Surname:
Organisation Name:		
Relationship to person being referred:		
Address:		
Postcode:	E-mail:	
Tel no:		Mobile:

Date of referral:	

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.