

Dementia Services Referral

All services require the person/s being referred to have a GP with East Cheshire

Please tick which service/s you require

| | |
|--|---|
| | <p>1:1 Admiral Nurse Support – person experiencing dementia must be on the GSF please tick 1 or more complex needs that referral is for from the below:</p> |
| | <p>1. <i>Health need of person living with dementia:</i> Person living with dementia demonstrates high levels of distress, poor physical/ mental health leading to decrease in well-being and carer (s) has difficulty with coping, poor understanding, indication of stress, anxiety or depression</p> |
| | <p>2. <i>Health of the carer/s:</i> Carer demonstrates poor physical mental health/ well-being, which has negative impact on care giving/ relationship and/ or adverse effect on person with dementia's well-being/ neglect.</p> |
| | <p>3. <i>Care giving skills:</i> Poor understanding and difficulty with coping, poor family dynamics which has negative impact on well-being & caregiving/ relationship and/or adverse effect on person with dementia's well-being/ neglect.</p> |
| | <p>4. <i>Risk:</i> Adverse effect on carer and/or person with dementia i.e. mental/ physical health, abuse, well-being</p> |
| | <p>Carers Wellbeing Course – 8 week educational course for carers aimed at early stage dementia</p> |
| | <p>Community Dementia Companions – matching service to enable to the carer to have 2hr respite weekly. Person does not require hands on care for and ADLs or mobility</p> |

| CARER DETAILS | |
|---|--|
| Has the person consented to the referral? <small>(we cannot proceed without consent)</small> | |
| Firstname | |
| Known as | |
| Surname | |
| DOB | |
| Gender | |
| Ethnicity | |
| Address | |
| Best contact number | |
| EMIS or NHS number if known | |
| Who is their emergency contact (name and number) | |
| Relationship to cared for | |
| Notable health issues | |

| PERSON EXPERIENCING DEMENTIA – DO NOT complete for 1:1 Admiral Nurse support | |
|--|--|
| Firstname | |
| Known as | |
| Surname | |
| DOB | |
| Gender | |
| Ethnicity | |
| Address (if different from carer) | |
| Best contact number (if different from carer) | |
| EMIS or NHS number if known | |
| Type of dementia | |
| Month and year diagnosed | |
| Are they aware they have dementia | |
| Do they live alone, if no who with | |
| Other notable health issues | |

| WHAT DO YOU WISH TO ACHIEVE FROM THE REFERRAL | |
|---|--|
| | Attendance of course for carer support |
| | Carer respite |
| | Carer 1:1 support |
| Any other comments: | |

| YOUR DETAILS | |
|----------------------------|----------------------------|
| Name: | Job title |
| | <i>If applicable</i> |
| Organisation | Tel number |
| <i>If applicable</i> | |
| Signature | Date: |
| | |