Enquiries: Dementia Services 01625 666990

Send to: cmicb-cheshire.echospicedementia@nhs.net

Post to: Millbank Dr, Macclesfield, SK10 3DR

Dementia Services Referral

Please check referral criteria and remit on the website before referring to prevent rejection

**Please tick which service/s you require**

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|  | **Dementia Carers Wellbeing Programme**– Knutsford, Congleton, Macclesfield, Poynton and Wilmslow, 8-week educational course for family carers aimed at early-stage dementia to learn more about dementia, option to bring person diagnosed with you and they will receive Cognitive Stimulation Therapy |
|  | **Community Dementia Companions** – volunteer led matching service to enable the carer to have 2hr weekly respite. Person does not require hands on care (mobility, toileting, eating, drinking) and carer lives with the person diagnosed |
|  | **Singing Together – once a month Macclesfield** wellbeingsinging, and dancing group held off site with live entertainment for carer and person experiencing dementia to attend together |
|  | **Love to Move Programme** **onsite**– once a week for limited period to experience brain gymnastics – seating exercises designed to stimulate cognition for person experiencing dementia |
|  | **End Stage Dementia Carers Talk –** for family caregivers to learn if their loved one may be in last year or life and where in last year, they may be. Held 3 times a year |

*By using our services, you are consenting to share your information, if you wish to opt out, please let us know*

*Please tick this box if you are a professional referring to confirm you have discussed consent with the people being referred*

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| **CARER DETAILS** |
| First name |  |
| Known as |  |
| Surname |  |
| DOB |  |
| Sex*please circle* |   M / F / Prefer not to say /   |
| Gender*please circle* |   M / W / Non binary /  Prefer not to say /  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is this the gender you were assigned at birth |   Yes / No |
| Ethnicity |  |
| Relationship to one another |  |
| Address |  |
| Best contact number |  |
| Your emergency contact (name andnumber) |  |
| Relationship to your emergency contact |  |
| Your notable health issues, allergies, diabetes etc |  |

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| **PERSON EXPERIENCING DEMENTIA**  |
| First name |  |
| Known as |  |
| Surname |  |
| DOB |  |
| Sex*please circle* |   M / F / Prefer not to say /   |
| Gender*please circle* |   M / W / Non binary /  Prefer not to say /  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is this the gender you were assigned at birth |   Yes / No |
| Ethnicity |  |
| Address (if different from carer) |  |
| Best contact number (if different from carer) |  |
| Type of dementia |  |
| Month and year diagnosed |  |
| Are they aware they have dementia |  |
| Do they live alone, if no who with |  |
| Do they use the toilet unaided |  |
| Do they eat and drink unaided |  |
| Do they walk unaided |  |
| Their notable health issues, allergies, diabetes etc |  |
| Who is their emergency contact (name and number) |  |
| Relationship with the emergency contact |  |

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| **SELF REFERRALS: HOW DID YOU HEAR ABOUT US?** |
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| **ANYTHING ELSE YOU FEEL WE NEED TO KNOW** |
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| **YOUR DETAILS** |
| **Name: Job title****…………………………………..** *If professional* **…………………………………..****Organisation Tel number***If a professional* **………………………………….. …………………………………..****Signature Date:****………………………………….. …………………………………..** |