Sunflower Living Well Dementia Services

Referral Form

Our basic criteria for referred to dementia service is; either carer or patient has a GP in our catchment area, there is a confirmed diagnosis of dementia by a doctor for the patient. We have many other services which are run as drop in’s. For further information please see website or call us.

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|  | **Dementia Carers Wellbeing Programme**– Knutsford, Congleton, Macclesfield, Poynton and Wilmslow, held 3 times a year in each location it’s an 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 |
|  | **Patient Social Support Programme** - Knutsford, Congleton, Macclesfield, Poynton and Wilmslow, held 3 times a year in each location it’s an 8-week cognitive stimulating activities group for the person diagnosed to enable the caregiver to have a break |

*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 |  | Surname |  |
| Preferred name |  | DOB |  |
| Gender  *please circle* | M / W / Non binary /  Prefer not to say /  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Sex  *please circle* | M / F / Prefer not to say |
| Is this the gender you were assigned at birth | Yes / No | Ethnicity |  |
| Relationship to patient |  | Carers best contact number |  |
| Address |  | **Carer’s emergency contact** (name and  number and relationship) |  |
| Carers health concerns |  | **Carers email required** |  |

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| **PATIENT DETAILS** | | | |
| First name |  | Surname |  |
| Preferred name |  | DOB |  |
| Gender  *please circle* | M / W / Non binary / prefer not to  say / Other……………. | Sex  *please circle* | M / F / Prefer not to say |
| Is this the gender you were assigned at birth | Yes / No | Ethnicity |  |
| Relationship to carer |  | Can the patient be contacted directly, if yes bets number |  |
| Address *(if different to carer)* |  | **Patient’s emergency contact** (name and  number and relationship) |  |
| Type of dementia and roughly when diagnosed |  | Other patient health concerns (diabetes, allergies etc) |  |
| Are they aware they have dementia? | Yes / No | Do they live alone? If no who with | Yes / No |
| Do they use the toilet unaided? | Yes / No | Do they eat and drink unaided? | Yes / No |
| Do they walk unaided? | Yes / No | Any other key info about functioning |  |
| Do they have any other support? Give details |  | Can they be left alone? | Yes / No |

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| **HOW DID YOU HEAR ABOUT OUR SERVICES?** |
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| **ANYTHING ELSE WE NEED TO KNOW (see website for list of services)** |
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| **YOUR DETAILS** |
| **Name: Job title**  **…………………………………..** *If applicable* **…………………………………..**  **Organisation Tel number**  *If applicable* **…………………………………..** *if not above* **…………………………………..**  **Signature Date:**  **………………………………….. …………………………………..** |