

**Younger people with dementia referral form**

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| The Younger People with Dementia team will only accept referrals for a person of working age. Service Users with suspected dementia **over the age of 65 should** be referred to Memory Services using the generic SPA referral form accessible on our website at: <https://www.leedsandyorkpft.nhs.uk/contact-us/urgent-referrals/>. **ALL** parts of this form should be fully populated, only complete forms will be considered by the service for an initial assessment. Failure to provide the full suite of information will result in a service decline letter being issued. Please return the form to referral.lypft@nhs.net  |

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| **SERVICE USER DETAILS** |
| **SURNAME** | Featherstone | **ADDRESS INC TOWN, COUNTY & POSTCODE** | 1019 Roman Grove, Roundhay, Leeds, West Yorkshire, LS8 2RS |
| **FORENAME** | Linda | **TELEPHONE NUMBER** | Landline: 0113 231 000Mobile: 07771918345 |
| **TITLE** | Mrs | **ETHNICITY** | Caucasian  |
| **SEX** | ☐Male☐Female | **LANGUAGE PREFERRED** | English |
| **DATE OF BIRTH** | 31/12/1974 | **IS AN INTERPRETER REQUIRED?** | ☐ Yes ☐ No |
| **NHS NUMBER** | 109473614 | **EMPLOYMENT STATUS** | Employed, Project Coordinator. |
| **MARITAL STATUS** | Married | **RELIGION** | Christian  |

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| **NEXT OF KIN DETAILS** |
| **SURNAME** | Featherstone | **ADDRESS INC TOWN, COUNTY & POSTCODE** | 219 Moortown Road, Moortown, Leeds, West Yorkshire, LS8 2TJ |
| **FORENAME** | Callum | **TELEPHONE NUMBER** | Home: 0113 450 999Mobile: 07771917345 |
| **TITLE** | Mr | **RELATIONSHIP** | Son |

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| **GP DETAILS** |
| **NAME** | Dr David Hughes | **ADDRESS INC TOWN, COUNTY & POSTCODE** | Greenside Medical Practice, Harrogate Road, Meanwood, LS6 2TY |
| **EMAIL** | D.hughes@email.com | **TELEPHONE NUMBER** | 0113 898 123 |
| **REFERRER DETAILS***(If different from GP details above)* | NA |

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| **REFERRAL DETAILS:** all information listed below is required for the service to assess the appropriateness of your patient for the service.  |
| a) Please provide a description of changes in the service users cognition and impact of changes on daily functioning for a minimum 6 month period *(service users must have a minimum history of 6 months changes in cognition & daily functioning to be considered for an initial assessment)* |
| Linda has commented she’s been unable to find her way round, finding this particularly challenging outside of her daily routine.  |
| b) Please provide information in relation to changes presenting in the Service user in the following – *attention/concentration, language, Memory, thinking/reasoning, Behavioural/Personality and Perceptual Abnormalities.* |
| Linda’s memory loss has been gradually getting worse over the last 12-18 months and is having an impact of many areas of her life. Examples include issues with house hold appliances (e.g. not remembering to turn the oven off, forgetting how to turn the gas fire on & leaving the fridge door open). Linda shared she often listens to her husband talk but isn’t able to fully understand the conversation. Family have commented she’s swearing a lot which isn’t like her & repeats things many times e.g. asks the same questions repeatedly. |
| c) Please provide the Cognitive Testing scores/result e.g. 6-CIT [Cognitive Impairment Test], GPCOG [General Practitioner Assessment of Cognition] or AMTS [Abbreviated Mental Test Score] |
| Linda undertook the 6-CIT test and scored 10/28. Linda answered all questions correctly with the exception of remembering the address. |
| d) Please provide full dementia screening bloods *(unless results accessible on Leeds Care Record)* |
| Blood results are accessible on Leeds Care Record. |
| e) What is the Service User’s current alcohol consumption per week in Units? |
| It varies, but roughly 6 pints of 4% beer per week, equating to14 units. |
| f) Has the Service User been abstinent from excessive alcohol consumption for more than 6 months? |
| Yes☐ No ☐ *Service Users with a history of excessive alcohol consumption must be abstinent for a minimum 6 month term prior to referral to the service.* |
| g) What is the Service User’s current and history of substance misuse? |
| Service user does not have a history of substance misuse and it not currently misusing substances.*Service Users with a history of substance misuse must be abstinent for a minimum 6 month term prior to referral to the service.* |
| h) Has the Service User experienced a head/traumatic brain injury in the last 12 months? If Yes please provide details. |
| Yes☐ No ☐ *Additional details:* |
| i) Has the Service User experienced a CVA [Cerebrovascular Accident] within the last 6 months? If Yes please provide details.  |
| Yes☐ No ☐ *Additional information:*  |
| j) Has delirium been excluded? *The YPWD team would not assess a service user presenting with a delirium.* |
| Yes☐ No ☐  |
| k) Please provide a summary of the Service Users Medical and Psychiatric history  |
| Service User is not on Leeds Care Record, therefore I have provided scanned medical and psychiatric history. |
| l) What is the Service Users current medication? |
| Service User is not on Leeds Care Record, therefore I have enclosed a copy of current medication & any known sensitivities. |
| m) Please advise if there is a family history of young onset dementia, and if so, please provide the type and age of onset. |
| Mother and Aunt both have been diagnosed with Vascular Dementia in their 50’s. |
| n) Please advise if there is a history of anxiety, depression or mood disorder, and if so, please include details of the current presentation.  |
| In 2015 Linda was treated for depression & anxiety. Zoloft was used during treatment. No current issues.  |
| o) Have mood disorders, such as depression & anxiety, as well as recent changes in medication been excluded as a cause prior to referral? |
| Yes☐ No ☐ Depression & anxiety have been treated prior to the referral. |

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| **CONTACTING THE PATIENT**  |
| p) May we telephone the patient on their mobile or send a text? |
| Yes☐ No ☐ *If no, please specify alternative contact preferred.* |
| q) Has the service user consented to family/carers to be contacted in conjunction with this referral *e.g. appointments.*  |
| ☐ Yes – service user has consented to sharing arrangements with a designated family member/carerCalum FeatherstoneHome: 0113 450 999Mobile: 07771917345☐ No – service user does not want family/carers to be contacted. |
| r) Has the service user consented to this referral?  |
| Yes☐ No ☐  |

Last updated: 14/06/2018