

**Younger people with dementia referral form**

|  |
| --- |
| 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](mailto:referral.lypft@nhs.net) |

|  |  |  |  |
| --- | --- | --- | --- |
| **SERVICE USER DETAILS** | | | |
| **SURNAME** |  | **ADDRESS INC TOWN, COUNTY & POSTCODE** |  |
| **FORENAME** |  | **TELEPHONE NUMBER** | Mobile:  Landline: |
| **TITLE** |  | **ETHNICITY** |  |
| **SEX** | ☐Male  ☐Female | **LANGUAGE PREFERRED** |  |
| **DATE OF BIRTH** |  | **IS AN INTERPRETER REQUIRED?** | ☐ Yes  ☐ No |
| **NHS NUMBER** |  | **EMPLOYMENT STATUS** |  |
| **MARITAL STATUS** |  | **RELIGION** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **NEXT OF KIN DETAILS** | | | |
| **SURNAME** |  | **ADDRESS INC TOWN, COUNTY & POSTCODE** |  |
| **FORENAME** |  | **TELEPHONE NUMBER** |  |
| **TITLE** |  | **RELATIONSHIP** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **GP DETAILS** | | | |
| **NAME** |  | **ADDRESS INC TOWN, COUNTY & POSTCODE** |  |
| **EMAIL** |  | **TELEPHONE NUMBER** |  |
| **REFERRER DETAILS**  *(If different from GP details above)* | Name:  Address:  Contact Number/Email: | | |

|  |
| --- |
| **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)* |
|  |
| 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.* |
|  |
| 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] |
|  |
| d) Please provide full dementia screening bloods *(unless results accessible on Leeds Care Record)* |
|  |
| e) What is the Service User’s current alcohol consumption per week in 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 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 |
|  |
| l) What is the Service Users current medication? |
|  |
| m) Please advise if there is a family history of young onset dementia, and if so, please provide the type and age of onset. |
|  |
| n) Please advise if there is a history of anxiety, depression or mood disorder, and if so, please include details of the current presentation. |
|  |
| 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 ☐ |

|  |
| --- |
| **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/carer  ☐ 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