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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*Referral Date** |  | **\*Referred by** |  | |  | | | |  |
| **\*Referrers role & contact details** |  | | | | | | | | |
| **\*Reason for referral** |  | | | | | | | | |
| **Person living with dementia (PLWD) details** | | | | | | | | | |
| **\*Name** |  | **\*Tel no** | | | | |  | | |
| **\*Male/Female** |  | **\*D.O.B** | | | | |  | | |
| **\*NHS no** |  | **\*Location in hospital** | | | | |  | | |
| **\*Confirmed dementia Diagnosis** |  | **\*Delirium screen completed** | | | | |  | | |
| **\*Ethnicity** |  | **\*First Language / Interpreter required** | | | | |  | | |
| **\*Home Address** |  | | | | | | | | |
| **\*Current presenting needs and relevant history (Background)** | | | | | | | | | |
| Include reason for admission to LTHT | | | | | | | | | |
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| **\*Carer Name** |  | | | **\*Carer Relationship to PLWD** | | | |  | |
| **\*Carer D.O.B or Age** |  | | | **\*Carer tel no. Work**  **Home** | | | |  | |
| **Email** |  | | | **Mobile** | | | |  | |
| **Ethnicity** |  | | | **\*First Language / Interpreter required:** | | | |  | |
| **\*Carer Address** |  | | | | | | | | |
| **Carer GP** |  | | | | | | | | |
| **\*Please confirm that consent has been gained from carer for referral** | | | | | | **YES / NO** | | | |
| **\*Background/Current situation:** | | | | | | | | | |
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**Admiral Nurse Team Use only**

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| **Date Referral Triaged** |  | **Triaged by** |  |
| **Outcome and rationale** | | | |
|  | | | |
| **Estimated date of first contact** |  | **Reason for rejection of referral** |  |