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REGISTERED IN IRELAND No. 244419
 REG. No. CHY 11416



Referral Form/Enquiry Sheet

Date			
Referred By			
Name	_____		
Address	_____ _____		
Tel No	_____		
Email	_____		
Details of Client (Please use Block Capitals)			
Name	_____		
Address	_____ _____		
Tel Number	_____		
Date of Birth	_____	Lives Alone Yes/No	_____
When Diagnosed	_____		
GP	_____	PHN	_____
Address	_____	Address	_____
Tel No	_____	Tel No	_____
Is client in receipt of Home Care Package?	Yes/No	_____	
Does client hold Medical Card?	Yes/No	_____	
Details of Primary Carer			
Name	_____		
Address	_____ _____		
Tel No	_____		
Email	_____		
Relationship to Client	_____		
Other Services Involved:	HSE Home Help Agency	Yes/No	_____
	Voluntary Agency	Yes/No	_____
Needs	Home Support	<input type="checkbox"/>	Cogs <input type="checkbox"/>
	Day Care	<input type="checkbox"/>	
	Respite	<input type="checkbox"/>	
	LTC	<input type="checkbox"/>	
	Other (please specify)	_____	

Western Alzheimers

Observations _____

WESTERN ALZHEIMERS OFFICE USE

Follow Up Report _____

Date Service Commenced _____
Service Reference _____
Letter from Doctor

Referred on: Maryfield Marian House WA Roscommon WA Ballindine
Other (please specify) _____

Type:	Dept:
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Ref:



Processing of Sensitive Personal Data

Western Alzheimers is committed to protecting the rights and privacy of individuals in accordance with the Data Protection Acts and Regulation (EU) 2016/679 (GDPR). Article 9 of the GDPR requires explicit consent from the Data **Subject for the processing of sensitive personal data** (e.g. **medical documents**).

If the information you are providing relates to 'sensitive personal data' as defined in GDPR, Western Alzheimer, requires explicit consent from you in order to obtain and process this information. For example; if you are disclosing information on conditions you suffer from or any medication you may be taking. To collect and store these records **for your convenience and to process those records you must sign the consent below.**

Data is retained solely for the purposes of providing _____ and is never shared with third party without your explicit consent.

Name	
Phone Number	
Comments	

I consent to Western Alzheimers processing the data including any sensitive personal data submitted with this form for the purpose of providing the consultation and/or service.

Signed Date