Service Referral Form

Person Living with Dementia:	
Address & Eircode:	
D.O.B.	
Civil Status	☐ Married ☐ Single ☐ Other:
Living Situation	*e.g. Alone, with spouse*
Name of Primary Carer:	***Please complete all questions of the Primary Carer Section***
Address & Eircode:	
Telephone:	
Date of Birth of Primary Carer:	
Email Address:	
Name of Person Making Referral if NOT Primary Carer:	
Address & Eircode:	
Contact No.:	
Has this referral been discussed with the Primary Carer?	
Is the PlwD being treated by anyone else? (Psychiatry of Later Life Team)	**Yes / No** If 'Yes' please specify:
What HSE services are in place? (Home-help)- Must be provided.	
Other services & Supports in place (private/meals on wheels/NFP):	

GALWAY BRANCH	MAYO BRANCH	ROSCOMMON BRANCH
Colonial Buildings, Eglinton Street, Galway H91 XWH3	Ballindine, Claremorris, Co. Mayo F12 PY99	Goff Street, Roscommon, F42 PR83
Tel: 091 565 193	Tel: 094 93 64900	Tel: 090 66 27816
Email: galway@westernalzheimers.ie	Email: info@westernalzheimers.ie	Email: roscommon@westernalzheimers.ie

www.westernalzheimers.ie

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Level of Dependency of the Person living with Dementia: (Please tick √)	**Immobile** **Uses Walking Aid** **Walks unaided** **Needs support with Activities of Daily Living** **Needs support with Personal Care/Toileting/Shower** **Other**

Please CIRCLE the service you require-

Dementia Advisor	In Home Support	Daycare	Social Clubs	Befriending Service	Family Mediation	Family Carer Training	Cognitive Stimulation Therapy	Carer Support Group Meeting

Date Referral was completed	
Other Information/Comments	**Notes- for office use only**

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GP REPORT

***Please have this GP Report completed by the service users GP & return all together.**

Patient's Name:	
D.O.B.	
Name of GP:	
Address:	
GP Contact No.:	
Is there a formal diagnosis of Dementia?	**Yes / No** *(Circle as appropriate)*
Type of Dementia *(Circle as appropriate)*	Alzheimer Disease / Vascular Dementia / Lewy Body Dementia / Fronto-Temporal Dementia / Other **If 'Other' please specify:**
Date of diagnosis:	
How often does the client attend the GP?	
Is the Client currently being treated for any other medical conditions?	**Yes / No** If 'Yes' please specify:
Past Medical History:	
Any known Allergies?	
Observations: Mobility/ Personal care/ Behaviour Observations	
List Medications:	
Additional Information from GP:	

I wish to refer the above-named individual for dementia specific services provided by Western Alzheimers.

GP Signature/Stamp:	
Date:	

Post to: Appropriate County Office- Details Below

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Data Consent Form

Version 4 16012023

Processing of Sensitive Personal Data

When a person is referred to **Western Alzheimers** for support, an electronic record with their name and additional information they provide will be recorded on a database. We use this information in order to be able to provide the best type of supports for people- we will also when deemed necessary share your information with other agencies such as the HSE, ASI, Private and Not for Profit Home Support Agencies (this list is not exhaustive) to help us determine what support and service we can provide to you. Services that we provide to individuals, including information given to us, are added to the record. You have the right, given by the Data Protection Act to submit a written request for a copy of your personal information at any time. All information will be treated with confidentiality.

Western Alzheimer's 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's 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.

The information we record is used only for the following purposes:

1. Processing the referral- personal details of client & NOK
2. Compiling statistical information on our database
3. Analysing Information for our funders
4. **Daycare service specific:-**
   Copy of current medication prescription
   Photograph (for identification purposes) – and use on our social media platforms
   Information regarding allergies/dietary requirements & celebrating of birthdays

Applicant Consent

I have read and understand the above statement in relation to Data Protection and consent to the use and disclosure of data and information as outlined.
I consent to this referral and that information may be shared as appropriate by relevant health care and social care professionals in processing this referral.

Applicant Name:	
Applicant Signature/ Person signing on behalf of applicant:	
Relationship to Applicant:	
Date:	
Western Alzheimer's Witness Signature:	
Date:	

If applicant is unable to sign consent, please provide details of person signing on behalf of applicant: