**DEMENTIA INTENSIVE SUPPORT SERVICE
REFERRAL FORM FOR EXTERNAL USE**

**Please use criteria below for guidance when referring:**

* **Must have an established dementia diagnosis**
* **Has the GP reviewed the patient for physical health issues and been given the all clear?**
* **Have all other avenues been explored by the care home when dealing with behaviours that challenge?**
* **Have you gained consent from the family?**

|  |
| --- |
| **Date of Contact:** |
| **Title:**  | **Name:** | **Alternative Names:** |
| **NHS Number:** | **Age:** | **D.O.B:** |
| **Ethnic Group** |  | **Interpreter required**  | **Yes** [ ]  | **No** [ ]  |
| **If yes, what is preferred language**:  |
| **Address**:  | **Access Difficulties:** |
| **Prev/Current Occupation:**  |
| **Town**:  | **GP Details** |
| **County**:  | **GP** |  |
| **Postcode**:  | **Address** |  |
| **Tel** (*Home*):  | **Contact Number** |  |
|  |
| **Next of Kin** |
| **Address**: | **D.O.B** (*if applicable*): |
| **Relationship**: |
| **Tel.** (*Home*): |
| **Postcode**: | **Tel.** (*Work*): |
| **Email Address**: | **Tel.** (*Mobile*): |
|  |
| **Main Carer** (*If different from next of kin*) |
| **Address**: | **D.O.B**: |
| **Relationship**: |
| **Tel.** *(Home)*: |
| **Postcode**: | **Tel.** *(Work)*: |
| **Email Address**: | **Tel.** *(Mobile)*: |
| **Is a carer’s assessment required?** | **Yes** [ ]  |  **No** [ ]  |
| **REASONS FOR REFERRAL**  |
|  |
|  |
| **Service User Informed** | **Yes** [ ]   **No** [ ]  |
| **Medical/Mental Health History**  |
| **Permanent or long standing health conditions or disabilities** |
|  |
| **Hospital Admissions during the last 12 months** (*Please state dates if known or date of last admission)*: |
|  |
| **Legal status** Is the service user on S117 **Yes** [ ]   **No ☐** |
|  |
| **Referrer Details** |
| **Team** |  |
| **Name** |  |
| **Case Manager** |  |
| **Date** |  |
| **Address** |  |
|  |
|  |
| **Triage** (*For use of DISS Team*) |
| **Duty Worker Triaging** |  |
| **Date**  |  |
| **Designation** |  |
| **Priority Assessment** (*Please tick as appropriate*) |
| **Eligibility Need** | Critical [ ]  | Substantial [ ]  | Moderate [ ]  | Low [ ]  |
| **Action**  | NFA [ ]  | Info/advice Given [ ]  | Referral for an Assessment [ ]  |
| **Priority**  | Urgent [ ]  | High [ ]  | Other [ ]  |