**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 | | | |