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**Please complete and send to:**

**Address:** Memory Technology Library,

The Grounds of Tipperary University Hospital, Clonmel. Co. Tipperary

Or

**Email:** **livingwellwithdementia@hse.ie**

**Memory** **Technology Resource Room**

 **Referral Form**

|  |
| --- |
| **Consent Received Y** 🞎 **N** 🞎  |
| Client name: |  | Contact person’s name |  |
| Gender:\* |  |  Contact person’s telephone no |  |
| Address: |  | Contact person’s relationship |  |
| Telephone No: |  |  Contact persons Email: |  |
| DOB:\* |  | GP Name & Address: |  |
| **Regarding the person with memory difficulties please comment on the following:**  |
| Lives Alone?  | Yes  | No - With whom / Details? |
| **Services availed of at present if any:**  **H**omecare 🞎 Day Centre 🞎 Respite Care 🞎**Other professionals / teams currently involved :**  |
| **Relevant Medical History of Person with memory difficulties:****Diagnosis of dementia** Yes 🞎 No 🞎 Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subtype if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Reason for Referral:**Information / education 🞎 Practical Strategies 🞎 Telecare options 🞎 GPS / trackers 🞎 Medication safety 🞎Falls prevention / Home safety 🞎 Cognitive Stimulation 🞎 Activities in home 🞎 Carer support / info 🞎**Details:** |
| **Assessment type***Folstein MMSE**MOCA* | **Score***/30**/30* | **Date completed** | **Assessment type***Addenbrooks Cognitive Evaluation III* | **Score***/100* | **Date completed** |
| **Any additional Information you wish to provide:**  |
| **Referred by*:(print name) \****  | **Discipline:**  |
| **Address:**  | **Email:**  |
| **Date:** |
| **Signature:**  |