|  |  |
| --- | --- |
| Received by |  |
| Database I.D |  |

Criteria to be considered for a referral:-

* live within Clackmannanshire, Stirling or Falkirk Council areas
* live with a diagnosis of a dementia or cognitive impairment.

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| Service Required |
| Post Diagnostic Support |   |
| Social Group Sessions  |  |
| Buddy Network  |  |
| Cognitive Stimulation Therapy (CST)  |  |

|  |  |  |
| --- | --- | --- |
| Demographic Data | Referred individual (PLwD)  | Carer/ other (Specify relationship)  |
| Relationship to referred |  |   |
| Title: |  |  |
| Full Name:  |  |  |
| Known as: |  |  |
| Address: |  |  |
| Date of Birth: |  |  |
| Telephone: |  |  |
| Email:  |  |  |

|  |  |  |
| --- | --- | --- |
| Medical Information | Referred individual (PLwD) |  |
| Diagnosis  |  |  |
| Date of diagnosis |   |  |

|  |  |  |
| --- | --- | --- |
| Points of contact (if different from carer)  | Emergency 1 | Emergency 2 |
| Name |  |  |
| Phone number |  |  |
| Address  |  |  |
| Email |  |  |
| Referrers Name |
| Name  |  |
| Position/ Self-referral |  |
| Telephone contact |   |
| Date |  |

Please return to **referrals@townbreak.org** or **Town Break, 1 Springkerse Road, Stirling, FK7 7SN.**

**N.B.** All information will be kept in accordance with data protection legislation. We will never share information without consent or unless we are required to by law.

**[ ENDS ]**