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

**Criteria to be considered for a referral**

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

|  |
| --- |
| Service Required |
| Social Group Sessions  |   |
| Buddy Network  |   |

|  |  |  |
| --- | --- | --- |
| Demographic Data | Referred (\*Person living with dementia)  | Carer/ other (Please specify relationship)  |
| Relationship to referred |  |   |
| Title: |  |  |
| Full Name:  |  |  |
| Known as: |  |  |
| Address: |  |  |
| Date of Birth: |  |  |
| Telephone: |  |  |
| Email:  |  |  |

|  |  |
| --- | --- |
| Medical Information | Referred individual (PLwD\*) |
| Dementia type (i.e. Alzheimer’s)  |   |
| Date of diagnosis |   |
| Info that could assist with the referral. |   |

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

**CONFIRM CONSENT**

**When submitting a referral please confirm** that the individual referred has been informed that their data will be passed to Town Break in order for contact to be made regarding possible help and support that can be offered.

**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.

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

**[ENDS]**