**Referral Form – Town Break Dementia Support**

**Criteria for Referral**

* Reside in the Clackmannanshire, Falkirk, or Stirling Council area.
* Have a diagnosis of dementia or evidence of cognitive impairment.

|  |  |
| --- | --- |
| Service Required (tick all that apply) | |
| Group Sessions |  |
| Town Break at Home |  |

|  |  |  |
| --- | --- | --- |
| Personal Information | Referred Individual (PLwD) | Care Partner (Please specify relationship) |
| Relationship to referred |  |  |
| Title: |  |  |
| Full Name: |  |  |
| Known as: |  |  |
| Address: |  |  |
| Date of Birth: |  |  |
| Telephone: |  |  |
| Email: |  |  |

|  |  |  |
| --- | --- | --- |
| Medical Information | Referred individual (PLwD\*) | |
| Dementia type (if known, e.g. Alzheimer’s) |  | |
| Date of diagnosis (if known) |  | |
| Additional information to support referral: |  | |
| EMERGENCY CONTACTS – TWO CONTACTS ARE REQUIRED  It is essential that you provide two emergency contacts. This ensures we can respond quickly in case of an emergency. | | |
| Points of contact | **Emergency 1** | **Emergency 2** |
| Name |  |  |
| Phone number |  |  |
| Address |  |  |
| Email |  |  |
| Referrers Details | | |
| Name |  | |
| Role / Relationship (e.g. GP, social worker, self-referral): |  | |
| Email address |  | |
| Telephone number |  | |
| Date |  | |

**CONFIRM CONSENT**

**By submitting this referral,** I confirm that the individual referred has given consent for their personal data to be shared with Town Break Dementia Support for the purpose of exploring appropriate support services. I understand that all information will be treated confidentially and handled in accordance with UK data protection legislation. It will not be shared with third parties without consent, unless required by law.

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