Younger People With Dementia (Berkshire) CIO

YPWD REFERRAL FORM

PERSONAL INFORMATION	
Name:	**Date of referral:**
Preferred name:	**Contact Number:**
Date of birth:	**Age:**
Email Address:	**Best way to contact:** direct/via referrer/via carer (please circle)
Marital Status:	
Address: **Postcode:**	
Diagnosis: **Date of Diagnosis if known:**	

CONTACT INFORMATION			
Carer Name: **Relationship:**		**Preferred Contact Details:** **Contact Number:** **Email Address:**	
Emergency Contact Name:		**Preferred Contact Details:** **Contact Number:** **Email Address:**	
Registered GP:			
Practice:			
Phone Number:			
Consultant:		**Contact Info:**	
Care Co-ordinator:		**Contact Info:**	
Referrer		**Contact Info:**	

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MEDICAL INFORMATION	
Current Cognitive Test Result and Date: i.e. MMSE	
Health Conditions: i.e. epilepsy, diabetes	
Medical History:	
Allergies:	
Dietary Needs:	
Smoker:	
DNAR: (Do not attempt resuscitation).	

Current Medication (please note any anti-psychotics):	**Medication to be taken during YPWD activity?**	**Times:**	**Dose:**

Any known side effects from medication?	

Please tick what benefits you aim to achieve for the person with dementia and their main carer.

Person with Dementia		Main Carer	
Build Confidence	☐	Reduce Stress	☐
Meaningful Activity	☐	Quality Time / Time for Self	☐
Reduce Anxiety	☐	Respite	☐
Improve Self-Esteem / Mood	☐	Provide Structure to the Week	☐
Provide Structure to the Week	☐	Reduce Anxiety	☐
Mental Stimulation	☐	Reduce Restlessness of Relative	☐
Physical Fitness	☐	Reduce Boredom of Relative	☐
Social Contact	☐	Social Contact	☐
Maintain Current Skills	☐		
Learn New Skills	☐		

Are there any other benefits you would like to achieve for the Person with Dementia?

Are there any other benefits you would like to achieve for the Carer?

Any other comments you would like to make or information you would like us to know?

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YPWD ASSESSMENT	
Mobility:	
Communication:	
Continence:	
Support Needs:	

In order for YPWD (Berkshire) to be able to offer the most person centred approach could you please take the time to complete the questions below?	
Life History:	
Former Occupations:	
Interests/Hobbies:	
Likes:	
Dislikes:	

Preferred choice of workshops:	

YPWD Assessment Notes:	
YPWD Plan:	
GDPR Signed:	**Photo Consent Signed:**
DCA Referral Requested:	**Admiral Nurse Referral Requested:**
YPWD Assessor:	
Date:	

YPWD – Client Contacted and Outcome

YPWD - Monitoring information

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Please indicate your ethnic origin	
Asian or Asian British ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Any other Asian background **Black or Black British** ☐ African ☐ Caribbean ☐ Any other Black background	**Mixed** ☐ White & Asian ☐ White & Black African ☐ White & Black Caribbean ☐ Any other mixed background **White** ☐ British ☐ Irish ☐ Any other White background **Other Ethnic Group** ☐ Chinese ☐ Any other ethnic group ☐ I do not wish to disclose this