 ****

|  |  |  |  |
| --- | --- | --- | --- |
| **Admiral Nurse Referral Form** | | | |
|  | | | |
| **Referral Criteria** (0ne or more of the following criteria must be met for the carer or other professionals) | | | |
| * The person with dementia is in their last year of life (e.g. more withdrawn, communicates less, changes to diet and fluid intake, less mobile, falls risk, ability to respond to changes in functioning/ physical health) * The family carer who cares for a person with dementia requires support as there are unresolved, complex needs that cannot be met by the current caring team * The person with dementia is registered with a GP in Denbighshire | | | |
| **Please note the Admiral Nurse is not an Emergency / Crisis Response Service** | | | |
| **Routine Referrals –** telephone response within 15 working days following receipt of the referral where possible.  **Urgent Referrals –** telephone response within 5 working days following receipt of the referralwhere possible. | | | |
|  | | | |
| **Referrer Details** | | | |
| **Name of Referrer:** | | | **Date:** |
| **Role:** | | | **Tel:** |
| **Base/ Organisation** | | | **Email:** |
|  | | | |
| **Main Carer Details** | | | **Additional Family Contact** |
| **Name:** | | | **Name:** |
| **Relationship to person with dementia:** | | | **Relationship to person with dementia:** |
| **Address:** | | | **Address:** |
| **Home Tel:**  **Work Tel:**  **Mobile:** | | | **Home Tel:**  **Work Tel:**  **Mobile:** |
| **GP Name:**  **Surgery:**  **Tel:** | | | **GP Name:**  **Surgery:**  **Tel:** |
|  | | | |
| **Person with Dementia Details** | | | |
| **Name:** | | | **D.O.B:** |
| **Address (if different from carer)** | | | **(if different from carer)**  **Home Tel:**  **Work Tel:**  **Mobile:** |
| **GP Name: (if different from carer)**  **Surgery:**  **Tel:** | | | **Diagnosis of Dementia: Yes No**  **Aware of diagnosis: Yes No**  **Type of Dementia:** |
| **Relevant Medical History/ Health Issues:** | | | **Other Agency Involvement:** |
| |  |  | | --- | --- | | Name: | DOB: | | | | |
| **Consent** | | | |
| **Has the person with dementia or carer consented to the referral Yes No** | | **Has the person with dementia or carer consented to information sharing Yes No** | |
|  | | | |
| **Reason for Referral/ Summary of needs:** | | | |
| **Reason for referral:**  Person has advanced dementia and carer/ family require support  Support required for professionals caring for a person with advanced dementia    **Summary of needs:**  Please tick all that apply  High levels of distress/change in presentation of the person with advanced dementia  Carer neglecting or unable to address their own needs  Presence of carer stress/anxiety and /or depression  Non-compliance with medications for person with advanced dementia and/ or carers  Need for support with developing skills to care for person with advanced dementia  Difficulty in adjusting to transitions between care environments  Support needed around end of life issues/ post bereavement support  Support needed with managing risk | | | |
| |  | | --- | | **Any other relevant information** | | | | |
| **For referrals or queries please contact:** | | | |
| **Admiral Nurse Anita Hagin**  **Tel:** 01745 585221  **Email:** [referrals@stkentigernhospice.org.uk](mailto:referrals@stkentigernhospice.org.uk)  [admiralnurse@stkentigernhospice.org.uk](mailto:admiralnurse@stkentigernhospice.org.uk) | **By Post:**  Admiral Nurse  St Kentigern Hospice  Upper Denbigh Rd  St Asaph  LL17 0RS | | |
|  | | | |
| **Admiral Nurse Use Only** | | | |
| **Date referral received:** | **Date contact made:** | | |
| **Referral route:** Post Tel Email In person | **Outcome:** Signpost Advice Group 1-1 | | |
| **Referred by:**  Self Relative  Nurse: Hospital Community - detail  Therapy: Hospital Community - detail  Social Services: - detail  Voluntary services: - detail  Other: | Level of intensity: High / Maintaining / Holding / Discharged | | |