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| **Admiral Nurse Referral Form** |
| **The following criteria must ALWAYS be met:** |
| * The carer must be over 18 and registered with a Kirklees GP. * The carer must be providing care and support for a person with a formal diagnosis of dementia (Not Mild cognitive impairment). * The carer is aware of the referral and agrees to it. |
| **For individual support (not group or courses) one or more of the following criteria must also be met:** |
| * The carer(s) are struggling to cope with the significant complex, challenging needs, or presentations of the person with dementia. * The carer(s) feels unable to cope with caring due to feelings of loss, guilt, stress, depression. * The carer(s) need support with psychosocial interventions to help them adjust and develop skills to support complex needs / behaviours, particularly around periods of transition. * The carer(s) require support due to their own physical or mental health impacting on their caring role. * Conflict has arisen between the carer, the family and the person with dementia, which is affecting the carers’ ability to care for the person with dementia. * The carer(s) need support with managing risk |
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| **The Admiral Nurses are not an Emergency / Crisis Response service. Admiral Nurses support family carers at all stages of the illness, including transitions through care.** |
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| * Referrals will be triaged by an Admiral Nurse as soon as possible after all the referral information is received. * Anyone contacting the Kirklees Admiral Nurses not fitting this criteria will be signposted to the Admiral Nurse Dementia helpline (the national phone line), or another relevant local service. |

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| **Referrer Details** | | | |
| **Date:** | | **Name and Organisation:** | |
| **Phone number:** | | **Email:** | |
| **Main Carer Details** | | | |
| **Name:** | | **DOB / NHS Number:** | |
| **Relationship to person with dementia:** | | **GP Surgery:** | |
| **Mobile number:** | **Telephone number:** | | **Email:** |
| **Address:**  **Post code:** |  | |  |
| **Person with dementia details** | | | |
| **Name:** | | **DOB / NHS Number:** | |
| **Diagnosis:**  **Diagnosis date:**  **Diagnosed by:** | | **GP Surgery:** | |
| **Is the person aware of their diagnosis?** | | | |
| **Address (if different to main carers):**  **Post code** | | | |
| **Please give details of any identified risks (carer or person with dementia):** | | | |
| **Is there any reason lone visits should not be undertaken?** | | | |
| **Reason for Referral / summary of needs:** | | | |
| **Other agencies involved in the care of the person with dementia and carer (if known) or referrals made:** | | | |
| **Other information (e.g. need interpreter, sensory impairments, housebound, working carers, children)** | | | |
| **The carer has given consent to this referral being made? YES / NO** | | | |
| **Please return completed forms to:**  [kirkleesadmiralnurses@swyt.nhs.uk](mailto:kirkleesadmiralnurses@swyt.nhs.uk)  Telephone: 01484 343126 | | | |