Dementia Wellbeing Service referral form

Email: dpn-tr.enquiriesbristoldementia@nhs.net only from a secure email address

If you need to send a referral via fax, please contact the above email to arrange

For more urgent advice please telephone the access point on 0117 904 5151 available 8am until 6pm Mon-Fri

Review Remedy RED FLAGS: https://remedy.bnssg.icb.nhs.uk/adults/dementia/dementia-assessment-referral/

1. Referral to cognitive neurology "**NBT Cognitive Disorders Clinic**" if**:** movement disorder/ history of seizures/ very rapid decline (significant cognitive decline <6 months)/ significant head injury with further cognitive decline since.
2. other specialist **referral routes** for patients with **HIV** or if you suspect **OSA** i.e. Respiratory/NIV clinic or features requiring initial neurology assessment.

Please discuss any uncertainty regarding this referral directly with your Dementia Practitioner before submitting

Your referral may not be accepted if you have not considered diagnosis independently

SECTION 1 – PATIENT DETAILS			
Full Name:		NHS No:	
DOB:		Phone number:	
Address & Postcode: (including address if current resident in Care Home)			
Contact details of significant other & relationship		Phone number:	
Ethnic origin		Religion	
Marital status		Sexual orientation	
Gender		Known disabilities	
What is their first language? Is an Interpreter required?		Language Interpreter **Yes** ☐ **No** ☐	
SECTION 2 – REFERRER DETAILS (If you are not the GP they must be aware of referral being made)			
Referrer name, Surgery & Designation			
Address & Contact details		Referral date:	

SECTION 3 – RISK & CONSENT

Current risks to patient _____

Potential risks to staff _____

Alcohol or drug misuse? Current: **Yes** ☐ **No** ☐ History: **Yes** ☐ **No** ☐
(Specify units of alcohol below)

Forensic history? **Yes** ☐ **No** ☐

Have you discussed this referral with the patient? **Yes** ☐ **No** ☐

Consented or, if lacks capacity, are you acting in their Best Interests (BI)?

Consented ☐ **Best Interests** ☐

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SECTION 4 – REASON FOR REFERRAL

- **For routine support and signposting following dementia diagnosis made by you/others** OR — **Yes** ☐ **No** ☐
- **Complex assessment and/or intervention due to a change in dementia/need** — **Yes** ☐ **No** ☐

What is the pre-existing diagnosis/your current working diagnosis? (please state)

Has a diagnosis of dementia been disclosed to the patient and family? (if 'No' please disclose before referring) — **Yes** ☐ **No** ☐

OR

- **For complex diagnosis** (if Yes complete next section with as much detail as possible) — **Yes** ☐ **No** ☐

Functional Changes: It can be difficult to distinguish functional decline and symptoms of dementia from general frailty, mood disorders, pain/ movement disorder or sensory impairment. The following are useful examples of what functional decline may look like and common symptoms of dementia:

Examples of functional decline i.e. NEW concerns:	**Common symptoms of dementia:**
• Problems with self-care, bathing, dressing, cleaning. • Problems with shopping/ cooking food, near misses leaving the hob on. • Not keeping track of bills, attending appointments/ social occasions. • Frequently losing things, needing others to find them/ finding them in unusual places. • Unable to problem-solve or plan activities in day-to-day life.	• Short term memory difficulty (long term usually good). • Word-finding-difficulty • Repetitive questions/ statements without recall (not enthusiasm/ impatience) • Reduced attention-span • Irritability, confabulation.

If you would like support making a diagnosis, please share the information you have gathered as part of your assessment.

NECESSARY: Are they continuing to drink alcohol? Specify units if known. Please refer to the alcohol pathway and discuss with the Dementia Practitioner if unclear.

NECESSARY: Evidence of functional decline?

NECESSARY: Cognitive screening completed and score? Where were most points lost?
If unable to complete cognitive testing please give clear evidence for cognitive impairment at interview.

If you found difficulty achieving a diagnosis what were the issues that require our intervention/assessment?

Has dementia been discussed as a potential diagnosis? **Yes** ☐ **No** ☐

Date of blood screen (within last 3 months)		Date of last CT head (less than 2 years old please unless otherwise discussed)	

Please attach CT results and Patient Summary