A black and blue logo

Description automatically generated

# Memory Support Service Referral Form

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Lincolnshire Memory Support Service (MSS) provides access to information, advice and support for people with dementia or mild cognitive impairment (MCI), their families and/or carers.  Please send this referral form as follows:  **Email:** [lpft.memorysupportservice@nhs.net](mailto:lpft.memorysupportservice@nhs.net)  **Tel:** 0303 123 4000  **(Only email if you have a secure email address or word protected)**  **Referrer Details: PLEASE NOTE: IT IS ESSENTIAL THAT ALL FIELDS ARE FULLY COMPLETED** | | | | | | | |
| Name of referrer: | | | | | Organisation: | | |
| Referrer’s job title: | | | | | Team: | | |
| Telephone number: | | Email: | | | | | |
| Is the person aware of the referral?  Choose an item. | | | | | | | |
| Date of referral: | | | Time of referral: | | | | |
| Phase of Dementia | Choose an item. | | | | | | |
| What is the diagnosis of the person? | Is the person aware of the diagnosis?  Choose an item. | | | | | | |
| Is Lasting Power of Attorney held?                 Choose an item. | | | | | | | |
| **Personal Details of the person being referred (Tick all that apply)** | | | | | | | |
| Person with Dementia or MCI | | | | Carer / Family Member | | | |
| Full name: | | | | Full name: | | | |
| Preferred name: | | | | Preferred name: | | | |
| Gender: Choose an item. | | | | Gender: Choose an item. | | | |
| Date of birth: | | | | Date of birth: | | | |
| Address: | | | | Address | | | |
| Postcode: | | | | Postcode: | | | |
| Telephone number: | | | | Telephone number: | | | |
| Mobile number: | | | | Mobile number: | | | |
| Email: | | | | Email: | | | |
| Preferred contact method: Choose an item. | | | | Preferred contact method: Choose an item. | | | |
| Preferred language: | | | | Preferred language: | | | |
| What support is requested by the patient? | | | | What support is requested by the carer? | | | |
| Specialist communication needs/ additional health conditions we should be aware of: | | | | Specialist communication needs/ additional health conditions we should be aware of: | | | |
| ***If the person with dementia or MCI requires assistance, by someone other than the carer in making an initial appointment, please provide details of an alternative contact below:*** | | | | | | | |
| Contact’s full name: | | | | | | | Title: |
| Known as: | | | | | | | |
| Relationship to person with Dementia or MCI: | | | | | | | |
| Address: | | | | | | | |
|  | | | | | | Postcode: | |
| Telephone number: | | Mobile No: | | | | | |
| E-mail: | | | | | | | |
| Preferred contact method: Choose an item. | | | | | | | |