ST. DAVID'S BRADBURY DAY CENTRE

REFERRAL FORM

To be completed by the referrer e.g. Health Visitor, Social Worker, GP, Neighbour or Relative with permission of the person being referred.

This form is available in large print, audio or can be translated if required

REFERRED PERSON DETAILS
NAME: **ADDRESS:** **TELEPHONE NUMBER:** **DATE OF BIRTH**: **AGE ON REFERRAL:** **LIVING SITUATION:** **EMERGENCY CONTACT NUMBER:**
NEXT OF KIN DETAILS
NAME: **ADDRESS:** **TELEPHONE NUMBER:** **EMAIL ADDRESS:**
OTHER CONTACT NAME (neighbour/friend)
NAME: **ADDRESS:** **TELEPHONE NUMBER:**
DOCTOR'S DETAILS
NAME: **SURGERY:** **CONTACT NUMBER:**

REFERRER
NAME: **ADDRESS:** **TELEPHONE NUMBER:** **DATE OF REFERRAL:**
REASON FOR REFERRAL:
If the person who is being referred is housebound, please state, also state the reason: **Does the referred person attend any other clubs or day centres, if yes please state:**

The person being referred will be contacted by an appropriate member of staff from the Centre to assess suitability. Due to the current COVID situation, referral visits will take place over the telephone.

If the referrer would like to be present at time of assessment, please state:

Please return to: info@stdavidsbradburydaycentre.org.uk

Karen Murdoch
Manager
St David's Bradbury Day Centre
57 St David's
Newtongrange
Midlothian
EH22 4LF

Telephone Number 0131 660 1285

Email:- info@stdavidsbradburydaycentre.org.uk

www.stdavidsbradburydaycentre.org.uk

ST. DAVID'S BRADBURY DAY CENTRE
REFERRAL ASSESSMENT FORM

General Health:

Mobility:

Sight:

Hearing:

Continence:

Special Dietary Requirements:

Allergies:

Appetite/Weight:

Sleep Pattern:

Other Illness or Disabilities:

Does the person have a diagnosis of dementia?

Date of diagnosis:

Type of dementia?

Speech Difficulties:

Medication:

Mental Health:

Orientation of time, place, person & things:

Memory:

Concentration:

Motivation:

Mood:

Behaviour:

Communication:

Expressing:

Understanding:

Wandering:

Restlessness:

Personal Skills:

Personality:

Sociability:

Domestic Care:

Personal Care:

Social Habits:

Carers:

Health:

Emotional Support:

Carers Group:

Carers Support Worker:

Past History:

Social Contacts:

Relevant Social Background:

Previous occupation:

Family:

Power of Attorney:

Is there a Do Not Resuscitate Order in Place?

Other services involved:

Religion:

Interests/Activities:

Pets:

Transport:

Can the person walk unaided to a car? Yes/No

Can the person get into the back seat of a car? Yes/No

Is a tail-lift ambulance required? Yes/No

Has the person a mobility aid? Yes/No

(if yes what type)

At the Centre

Assistance with toileting? Yes/No

Management for continence? Yes/No

Assistance with walking inside? Yes/No

Assistance with eating/drinking? Yes/No

Assistance with clothing? Yes/No

Alcohol? Yes/No

Assessor:

Is the person suitable for the Centre?

If no, brief explanation why

Information given to referrer **Date:** **By:**

Place Offered **Date:** **By:**

Would it be desirable to have a member of staff visit prior to attendance?

Visit Arranged: **Date:**

Place Accepted:

If yes, transport arrangements organised by:

Start Date: