****

**Please complete and send to:**

**Address:** Memory Technology Library,

The Grounds of Tipperary University Hospital, Clonmel. Co. Tipperary

Or

**Email:** [**MTRR.SouthTipperary@hse.ie**](mailto:MTRR.SouthTipperary@hse.ie)

**Memory** **Technology Resource Room**

**Referral Form**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Consent Received Y** 🞎 **N** 🞎 | | | | | | | | | |
| Client name: |  | | | | Contact  person’s name | | |  | |
| Gender:\* |  | | | | Contact person’s  telephone no | | |  | |
| Address: |  | | | | Contact person’s relationship | | |  | |
| Telephone No: |  | | | | Contact persons Email: | | |  | |
| DOB:\* |  | | | | GP Name & Address: | | |  | |
| **Regarding the person with memory difficulties please comment on the following:** | | | | | | | | | |
| Lives Alone? | Yes | | | No - With whom / Details? | | | | | |
| **Services availed of at present if any:**  **H**omecare 🞎 Day Centre 🞎 Respite Care 🞎  **Other professionals / teams currently involved :** | | | | | | | | | |
| **Relevant Medical History of Person with memory difficulties:**  **Diagnosis of dementia** Yes 🞎 No 🞎 Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subtype if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **Reason for Referral:**  Information / education 🞎 Practical Strategies 🞎 Telecare options 🞎 GPS / trackers 🞎 Medication safety 🞎  Falls prevention / Home safety 🞎 Cognitive Stimulation 🞎 Activities in home 🞎 Carer support / info 🞎  **Details:** | | | | | | | | | |
| **Assessment type**  *Folstein MMSE*  *MOCA* | | **Score**  */30*  */30* | **Date completed** | | | **Assessment type**  *Addenbrooks Cognitive Evaluation III* | **Score**  */100* | | **Date completed** |
| **Any additional Information you wish to provide:** | | | | | | | | | |
| **Referred by*:(print name) \**** | | | | | | **Discipline:** | | | |
| **Address:** | | | | | | **Email:** | | | |
| **Date:** | | | |
| **Signature:** | | | | | | | | | |