

**Please complete and send to:**

Memory Technology Library,

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

***Continued overleaf***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Consent Received Y 🞎 N 🞎** | | | | | | | **Date of Referral:** | | | |
| **Client name:** |  | | | | | | **Contact**  **person’s name** | |  | |
| **Address:** |  | | | | | | **Contact person’s telephone no.** | |  | |
| **Telephone No:** |  | | | | | | **Contact person’s relationship** | |  | |
| **Gender:** |  | | | | | | **Contact person’s email** | |  | |
| **DOB:\*** |  | | | | | | **GP Name & Address**: | |  | |
| **Regarding the person with memory difficulties, please provide the following details.** | | | | | | | | | | |
| |  | | --- | | **Past Medical History of Person with memory difficulties: *(*please list all*)*** | | **Diagnosis of Dementia (given by Medical Doctor)**  **Yes 🞎 No 🞎**    **Date of diagnosis**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Subtype** (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| **Living Alone? Yes 🞎 No 🞎** | | | | With whom: | | | | | | |
| **Services availed of at present** | | | | Home supports 🞎 Day Centre 🞎 Respite 🞎 Other 🞎 | | | | | | |
| **Other professionals/teams currently involved** | | | | Primary Care, ICPOP, Rehab, Mental Health Services, Other | | | | | | |
| **Reason for Referral:** Please include any relevant observations/findings relating to how cognitive decline is impacting on function, mood, behaviour | | | | | | | | | | |
| **Dementia post diagnostic support/information/education** | | | | | 🞎 | ***Please provide relevant detail for the referral here:*** | | | | |
| **Dementia carer support / information** | | | | | 🞎 |
| **Dementia brain health education** | | | | | 🞎 |
| **Practical Strategies** | | | | | 🞎 |
| **Falls prevention / Home safety technologies/ Telecare options** | | | | | 🞎 |
| **Medication management/safety** | | | | | 🞎 |
| **Cognitive Stimulation Advice** | | | | | 🞎 |
| **Assessment Results** | | | | | | | | | | |
| **Cognitive**  **Screening Tool** | | **Score** | **Date completed** | | | | **Cognitive**  **Screening Tool** | **Score** | | **Date completed** |
| Folstein MMSE | | /30 |  | | | | Mini Addenbrooks  Cognitive Evaluation (m-ACE) | /30 | |  |
| Addenbrooks Cognitive Evaluation 111  (ACE 111) | | /100 |  | | | | Other |  | |  |
| **Additional Information Relevant to this Referral:** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Referred by*:(print name) \**** | | | | | | | **Discipline:** | | | |
| **Address:** | | | | | | | **Email:** | | | |
| **Date:\*** | | | |
| **Signature:** | | | | | | | | | | |

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| **For MTRR Office Use Only** |
| **Note** |