

**Please complete and send to:**

Memory Technology Library,

Grounds of Tipperary University Hospital, Clonmel, Co. Tipperary

Or

**Email:** **MTRR.SouthTipperary@hse.ie**

Memory Technology Resource Room Referral Form

***Continued overleaf***

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| **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.**  |
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| **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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **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 AddenbrooksCognitive 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** |