

YPWD REFERRAL FORM

PERSONAL INFORMATION			
Name:		Date of referral:	
Preferred name:		Contact Number:	
Date of birth:		Age:	
Email Address:		Best way to contact: direct/via referrer/via carer (please circle)	
Marital Status:		Religion:	
Address:			
Postcode:			
Diagnosis:			
Date of Diagnosis if known:			
CONTACT INFORMATION			
Carer Name:		Preferred Contact Details:	
		Contact Number:	
Relationship:		Email Address:	
Emergency Contact Name:		Preferred Contact Details:	
		Contact Number:	
		Email Address:	
Registered GP:			
Practice:			
Phone Number:			
Consultant:		Contact Info:	
Care Co-ordinator:		Contact Info:	
Referrer		Contact Info:	

MEDICAL INFORMATION

Current Cognitive Test Result and Date: i.e. MMSE	
Health Conditions: i.e. epilepsy, diabetes	
Medical History:	
Allergies:	
Dietary Needs:	
Smoker:	
DNAR:	

Current Medication (please note any anti-psychotics):	Medication to be taken during activity?	Times:	Dose:
Potential Risks:			

**Please tick what benefits you aim to achieve
for the person with dementia and their main carer.**

Person with Dementia		Main Carer	
Build Confidence	<input type="checkbox"/>	Reduce Stress	<input type="checkbox"/>
Meaningful Activity	<input type="checkbox"/>	Quality Time / Time for Self	<input type="checkbox"/>
Reduce Anxiety	<input type="checkbox"/>	Respite	<input type="checkbox"/>
Improve Self-Esteem / Mood	<input type="checkbox"/>	Provide Structure to the Week	<input type="checkbox"/>
Provide Structure to the Week	<input type="checkbox"/>	Reduce Anxiety	<input type="checkbox"/>
Mental Stimulation	<input type="checkbox"/>	Reduce Restlessness of Relative	<input type="checkbox"/>
Physical Fitness	<input type="checkbox"/>	Reduce Boredom of Relative	<input type="checkbox"/>
Social Contact	<input type="checkbox"/>	Social Contact	<input type="checkbox"/>
Maintain Current Skills	<input type="checkbox"/>		
Learn New Skills	<input type="checkbox"/>		

Are there any other benefits you would like to achieve for the Person with Dementia?

Are there any other benefits you would like to achieve for the Carer?

Any other comments you would like to make or information you would like us to know?

YPWD ASSESSMENT

Mobility:

Communication:

Continance:

DNAR:

In order for YPWD (Berkshire) to be able to offer the most person centred approach could you please take the time to complete the questions below?

Life History:

Former Occupations:

Interests/Hobbies:

Likes:

Dislikes:

Preferred choice of workshops:

YPWD Assessment Notes:

YPWD Plan:

GDPR Signed:

Photo Consent Signed:

DCA Referral Requested:

Admiral Nurse Referral Requested:

YPWD Assessor:

Date:

YPWD – Client Contacted and Outcome
