

1. **Basic Information**

Name:

Preferred name:

Date of Birth (dd/mm/yyyy): Gender:

Address:

Town: Swanage Postcode:

Accommodation:

Hints on finding the address:

(if difficult)

Contact No (H): 426288 (M)

Name of GP: GP No:

Name of GP Practice:

First Emergency Contact: Tel No:

Second Emergency Contact: Tel No:

Next of Kin: Tel No:

1. **Other Information**

Relevant Medical History:

(Continue on A4 sheet if not enough space)

Reason for Referral:

Does the client suffer from short term memory loss? (Has there been a diagnosis?)

Name of Social Worker:

Is there a Personal Care Budget: Yes / No

If Yes, does it cover Social isolation: Yes / No

Are there any communication difficulties?

Suggestions for activities?

1. **Person Referring**

Name:

Agency/Organisation/

Relationship to person referred:

How long have you known the person referred?

Contact No:

Email:

**The person referred has agreed to this referral**

Signed: Referral Date:

**Data Protection Statement**

Please note that all information contained within this document will be stored and utilised within the guidelines of GDPR regulations and – where necessary - the appropriate consent will be obtained from those about whom we hold information.

Once completed, please return this document to:

**Link Visiting Swanage**

**21 Commercial Road**

**Swanage BH19 1DF**

**e-mail:** swanage@linkinglives.uk **Tel. No.** 07495 534171