**Thank you for referring to the Dementia Advocacy Service. Please complete this form as thoroughly as possible to help us assess and address the needs of the individual being referred.**

## SECTION 1: REFERRER DETAILS

|  |  |
| --- | --- |
| **Name of Referrer:** |  |
| **Organisation (if applicable):** |  |
| **Role/Title:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |
| **Date of Referral:** |  |

**Relationship to the Individual Being Referred: Please ☑**

**[ ] Family Member [ ] Friend [ ] Professional**

**[ ] Other (please specify):**

## SECTION 2: INDIVIDUAL BEING REFERRED

|  |  |
| --- | --- |
| **Full Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Postcode**  |  |
| **Contact Number:** |  |
| **Email Address (if available):** |  |
| **Primary Diagnosis (if known):** |  |

**Is the Individual Aware of This Referral? (Please ☑)**

**[ ] Yes [ ] No**

**Does the Individual Have a Diagnosed Dementia? (Please ☑)**

**[ ] Yes [ ] No**

**Preferred Language(s):**

**Communication Needs (e.g., visual/hearing impairments, language needs):**

## SECTION 3: CARER/PRIMARY CONTACT DETAILS (IF APPLICABLE)

|  |  |
| --- | --- |
| **Name of Carer/Primary Contact:** |  |
| **Relationship to the Individual:** |  |
| **Contact Number:** |  |
| **Email Address:** |  |

## SECTION 4: REASON FOR REFERRAL

**Reason for Referral (please provide a brief summary of the individual’s needs):**

**Please Tick ☑ Areas of Support Required:**

[ ] Understanding the Dementia Diagnosis [ ] Accessing Local Services/Resources

[ ] Support with Benefit/Disability Forms [ ] Advocacy for Health and Social Care Issues

[ ] Planning for Future Care [ ] Connecting with Peer Support or Community Activities

[ ] Carer Support or Respite Guidance [ ] Other (please specify):

## SECTION 5: CONSENT AND PRIVACY

**Consent for Referral: (Please Tick ☑)**

**I confirm that the individual has given their consent for this referral: [ ] Yes [ ] No**

**Privacy Statement:**

Information provided in this referral will be used solely to assess and deliver the necessary support. Data will be stored securely in line with GDPR and Data Protection Act 2018 regulations.

|  |  |
| --- | --- |
| **Referrer’s Signature:** |  |
| **Date:** |  |

## SECTION 6: ADDITIONAL INFORMATION

**Please provide any other relevant information that may assist in delivering support:**

## Submission Instructions: Please send the completed referral form to:

**Email:** **dcas@mhmwales.org.uk** **Post: Mental Health Matters Wales, Union Offices, Quarella Road, Bridgend, CF31 1JW. Telephone for Queries: 01656 650 451 Referral forms can also be downloaded from our website. Visit www.mhmwales.org.uk for more information. Thank you for your referral. We will be in touch within 2 working days**