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Description automatically generated](https://www.ageuk.org.uk/croydon/)

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| Memory Tree café (Dementia café) referRal form |
| All questions contained in this questionnaire are strictly confidential. Incomplete forms will be returned. **Please send completed referrals to:** [**memorytreecafe@ageukcroydon.org.uk**](mailto:memorytreecafe@ageukcroydon.org.uk) |

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| **Is the client aware of and agreeable to this referral?** YES or NO | **Is the client happy for Age UK Croydon to store this data?**  YES or NO |
| **Referrer name:**  **Referrer organization:**  **Referrer phone number:**  **Referrer Email address:** | **Does the client live alone?**  **If the client does not live alone who do they live with?**  **If client lives in supported living/care/residential home please specify.** |
| **Name:** | **DOB:** |
| **Address:**  **Phone number:**  **Mobile number:**  **Email address:** | **Gender:**  **Ethnicity:** |
| **Details of main carer**  **Name:**  **Address:**  **Phone number**  **Mobile number**  **Email address:** | **Gender:**  **Ethnicity** |
| **Next of Kin name (if different from above):**  **Next of Kin relationship to client:**  **Next of Kin contact number:** | **Is the client a Notting Hill Genesis Housing Association Resident?**  YES or NO |
| **Does the person named above….**  **Have a dementia diagnosis?** YES or NO  **What type of dementia has been diagnosed (if known)?**  **Approximately when did they receive the diagnosis?**  **Are they awaiting a dementia diagnosis?** YES or NO  **Brief description of current impact of dementia on daily activities** | **Does the person named above…..**  **Need walking aids or support to walk? If so please specify**  **Have a history of falls? If so please specify**  **Have vision or hearing loss?**  **Have any allergies?**  **Can they communicate verbally?** |

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| **Please tell us about the client…..**  **Likes/Dislikes:**  **Hobbies/Interest:**  **Favourite music:** |

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| **Baseline Monitoring**   1. I feel confident in trying new things (circle one)   All the time Some of the time Rarely Never   1. I take part in regular activities that I find enjoyable (circle one)     All the time Some of the time Rarely Never   1. I have enough opportunities to meet and speak to others (circle one)   All the time Some of the time Rarely Never   1. I am getting support from   Alzheimer’s Society Carer’s Centre Day Centre/s Any other dementia services   1. Where did you hear about us? |

**I or my carer, give my consent and permit Age UK Croydon to record personal information about myself in accordance with Age UK Croydon’s Safeguarding Adults, Data & Confidentiality Policies** (I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn).

For carers; I understand that staff running the Memory Tree Café are NOT carers and CANNOT undertake caring duties or be held responsible for anybody’s personal care, safety or whereabouts.

For carers; I understand if the person I care for/am responsible for (named above) is not independent enough, they should be accompanied by myself or someone else who can be responsible for them.

Name of Client (print clearly): ……………………………………………………………………………………………………………………………

Signature: ………………………………………………………………………………Date: ………………………………………

Name of Carer (print clearly): ……………………………………………………………………………………………………………………………

Signature: ………………………………………………………………………………Date: ………………………………………

***Please now complete the Pre-Activity Readiness Questionnaire (PARQ) on the page below which must be filled out by anyone taking part in exercise/physical activity at the Memory Tree Cafe.***

***Incomplete forms will not be accepted.***

***Carers taking part in exercise need to complete a PARQ too.***

**Pre-activity readiness health questionnaire – Memory Tree Cafe**

For most people, physical activity does not pose a hazard, however, you are advised to consult your doctor before undertaking any physical activities.

1. Are you accustomed to physical exercise? Yes No
2. Has your doctor ever said you have a heart condition? Yes No
3. Do you feel pain in your chest or legs when you do physical activity? Yes No
4. Do you ever lose balance because of dizziness or ever lose consciousness? Yes No
5. Do you have uncontrolled high/low blood pressure? Yes No
6. Do you have a bone or joint problem such as arthritis that could be made worse by a change in your physical activity? Yes No
7. Is there a physical reason not mentioned here, or has a doctor ever advised that you should not follow an activity programme? Yes No

Any other health/medical conditions/symptoms

Medication prescribed.

Do you have a disability?

GP Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Details:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Declaration**

I understand that if I have answered ‘Yes’ to one or more of the above medical questions, or have any unstable condition not controlled with medication, I should seek medical advice before attending an activity programme. I agree to inform AUKC if there is a change in my medical condition. I understand that this information will be shared with other activity leaders, but will be kept confidential from third parties, and I take part in the activity at my own risk. I am fully aware of the risks involved; I understand I am responsible for my own safety.

Signature…………………………………………………………………Date………………...

**Or** Carers Signature (on behalf of client)……………………………………… Date……………