Anam Croí
The heart and soul of Claregalway

REFERRAL FORM

Please complete in Block Capitals
Please note: *all personal sensitive information received is confidential, will not be shared, and will only be accessed when necessary under the terms of Data Protection regulation.*

Personal Details

Name:

Likes to be known as:

Date of Birth:

Address *(please include Eircode)*:

Tel No *(Home)*:

Tel No *(Mobile)*:

Hobbies/Interests:

Dislikes:

091 739385 | 086 445 8989
info@anamcroi.ie
Gortnacreige, Creigboy,
Claregalway, H91 XR7R

Diet:

☐ Normal Soft ☐ Diabetic ☐ Pureed ☐ Other

If other please specify:

Special Dietary Requirements:

Can eat independently: ☐ Yes ☐ No

Assistance required: ☐ Yes ☐ No

If yes, please specify *(needs food cut up, uses fingers/spoon etc)*: :

Living Situation:

☐ Living alone ☐ Living with spouse ☐ Living with family ☐ Other

If other please explain:

Current Supports:

☐ Home help ☐ Meals on wheels ☐ Psychiatry of Later Life

Will Transport be required?: ☐ Yes ☐ No

Medical Details

Reason for referral:

Official Diagnosis:

Allergies (drug, food, other):

Is there a diagnosis of dementia? ☐ Yes ☐ No

If yes, what type?

☐ Alzheimer's Disease ☐ Vascular Dementia ☐ Lewy Body Dementia ☐ Other

If other please specify:

Year of diagnosis of dementia?

Is there symptoms of anxiety/confusion? ☐ Yes ☐ No

If yes, what helps?

Is there a history of depression? ☐ Yes ☐ No

Does this person suffer pain? ☐ Yes ☐ No

If yes, what is the cause of the pain and what helps relieve it?

Any other conditions we need to be aware of *(i.e. hypertension, asthma, hard of hearing, sight etc)*?

Level of dependency?

☐ Immobile ☐ Uses walking aid ☐ Needs support with ADL

☐ Walks unaided ☐ Wears continence aids ☐ Needs support with personal care

☐ Other

If other, please explain:

History of falls? ☐ Yes ☐ No

If yes, please explain:

Have you received the Covid-19 Vaccine? ☐ Yes ☐ No

Date Vaccine(s) Received:

Type of vaccine *(i.e. Pfizer, Astro Zenica, Moderna, Johnson & Johnson etc)*

Condition of skin

☐ Satisfactory ☐ Dry

Any Wounds: ☐ Yes ☐ No

Location of wound/s:

Any history of hospital infections? ☐ Yes ☐ No

If yes, which:

Any further information you would like to add?

GP/ Public Health Nurse Contact Details

Please attach the following information, the referral will not be actioned until all information is received.

- Letter from GP covering medical history
- Copy of current prescription
- Passport size photo

GP Name:

GP Tel No:

GP Address:

PHN Name:

PHN Tel No:

Health Centre:

Contact Details – Next of Kin (x2)

Name:

Name:

Relationship:

Relationship:

Tel No *(Home)*:

Tel No *(Home)*:

Tel No *(Mobile)*:

Tel No *(Mobile)*:

Signature

Signature of person making referral:

Date:

Print Name: