



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



Gort na Creige, Cregboy,
Claregalway, H91 XR7R



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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:

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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: