Anam Croí
The heart and soul of Claregalway

DAY CENTRE REFERRAL FORM

About Anam Croí Day Centre:

The Anam Croí Day Centre is based in Claregalway and is designed as a welcoming and supportive space at the heart of the community. Seniors can come together to meet friends, share stories, and spend meaningful time in each other's company.

A Typical Day Includes:

- Refreshments on arrival
- Gentle seated exercises & relaxation
- Activities including Arts & Crafts, Cards, Bingo, Music & Entertainment
- Hot lunch
- Transport within 10km of Claregalway

We understand that many seniors struggle with feelings of loneliness and isolation, and we work hard to create a caring and compassionate environment that fosters a real sense of community and belonging.

We kindly ask that you complete and return this referral form to
Anam Croí Day Centre, Gort na Creige, Cregboy, Claregalway, H91 XR7R.

Please include the following with your application: a letter from your GP outlining medical history, a copy of your current prescription and a passport-sized photo.

If you need any additional information, please do not hesitate to contact us on
Tel: 091-739385, 086-4458989
Email: info@anamcroi.ie

This form can also be completed online at **www.anamcroi.ie**.

Personal Details: *Please complete in Block Capitals*

Name:

Likes to be known as:

Date of Birth:

Address (*please include Eircode*):

Tel No (*Home*):

Tel No (*Mobile*):

Hobbies/Interests:

Dislikes:

Living Situation & Current Supports: ***(tick all that apply)***

Living alone ☐ Living with spouse ☐ Living with family ☐
Nursing Home ☐ Home Help ☐ Carer ☐
Meals on Wheels ☐ Psychiatry of Later Life ☐ Other ☐

If other, please specify:

Will bus transport be required?:

Yes ☐ No ☐

Please Note: *Bus transport is only available to those living within a 10km radius of the Day Centre in Claregalway.*

Diet (please specify usual food type/requirements):

Normal ☐ Diabetic ☐ | Pureed ☐ Chopped ☐ Other: (*Please Specify*)

Can eat independantly:

Yes ☐ No ☐

If **No,** please specify

Medical Details:

Reason for referral:

Official Diagnosis:

Allergies (Drug, Food, Other):

Yes ☐ No ☐

If **Yes,** please specify

Is there a diagnosis of Dementia:

Yes ☐ No ☐ Alzheimer's ☐ | Lewy Body Dementia ☐

If **Yes,** please specify Vascular Dementia ☐ | Other: (*Please Specify*) ☐

Symptoms of confusion: Yes ☐ No ☐ | **Confusion Level:** Mild ☐ Moderate ☐ Severe ☐ | **Year of Dementia Diagnosis:** ☐

What helps with the confusion? (*If applicable*)**:** ☐

Is there a history of Depression / Anxiety?: Yes ☐ No ☐

Depression / Anxiety Severty Level (*if applicable*)**:** Mild ☐ Moderate ☐ Severe ☐

Does this person suffer from pain or discomfort?: Yes ☐ No ☐

Pain Severty Level (*if applicable*)**:** Mild ☐ Moderate ☐ Severe ☐

What is the cause of the pain and what helps releive it?: (*If applicable*)**:**

☐

Please list any other conditions we should be aware of:
(*hypertension, asthma, hard of hearing, vision impaired etc.*)

☐

Level of mobility/dependancy (tick all that apply): Immobile ☐ Walks unaided ☐

Uses walking aid (rollator etc.) ☐ Wears continence aids ☐ History of falls ☐

Needs support with ADL Needs (personal care, toileting etc.) ☐

Other (*please specify*) ☐

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*)?

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?

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.

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: