DUNBAR DAY CENTRE
REFERRAL FORM

Thank you for your interest in using our service. Please indicate which service you are inquiring about:

Building Based Service ◯

Community Outreach & Respite Support ◯

Please fill as much of the information in as you can. If you are not comfortable answering some of the questions now, our staff will follow them up on a referral visit.

Date of Referral:

Name: D. O. B:
Address:

Tel Number:

Referrer Name: Relationship to client:
Organisation:
Tel number:
Reason for referral:

Next of kin:
Address:

Emergency daytime contact:

Name and Address of Power of Attorney (if applicable)
Please note that staff are required by law to see the original copy of any POA
Wellbeing
Financial
Both

GP: Surgery:

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Tel number:

What do you hope to get from using our service?
Carer Respite, friendship, break from the house,etc.

Health
Please list all medical conditions including any medical allergies
Diabetes – Yes/No
Dementia – Yes/No
Any other health issues e.g., heart, stroke, blood pressure

Is prompting required to take medication? Yes/No

Do you consent to Dunbar day centre holding a copy of your medication list which we will obtain from yourself or your GP surgery? Yes/No

Mobility

Do you need help to walk?

Do you use walking/ mobility aids like a walking stick, crutches, wheelchair, hoist, etc?

Can you use stairs?

Dietary requirements/food allergies:
Do you need help eating and drinking?

Do you need adapted cutlery?

Any dietary requirements? (Celiac/ Gluten Free/ Kosher/ Hallel)

Any Food allergies?

Do you require an Epipen?
Do you have to test blood sugar levels?

Other services
Home care Yes/ No
Days and times:
Care Agency Provider:

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District nurse: Yes/No
Frozen meals Yes/No

Care Manager: Yes/No
Name and contact details:

Aids – glasses/hearing aid/special cutlery/stick/walking frame/wheelchair/other

If aids used, please state frequency e.g. uses a wheelchair for longer distances only

Personal Care
Do you need help with?
Toileting?

Memory?

Communication?

Mood management?

Home Circumstances
Do you live alone? Yes/No
Who do you live with?

Type of accommodation – Upstairs flat/ground floor flat/bungalow/house
Bathroom – upstairs/downstairs
Bedroom – upstairs/downstairs

Consent to sharing information.
Information above will be treated confidentially. There may be occasions (for medical reasons or other emergencies) when this information may need to be passed to other agencies.

I …… consent/do not consent to my details being shared with other agencies in an emergency or matters of safety.