# Date of assessment :

# Client Details

| Full Name: | What would you like to be known as?  |
| --- | --- |
| Date of Birth: | Gender: |

# Contact Information

| Address |  |
| --- | --- |
| Mobile Phone |  |
| Telephone Number |  |
| Email |  |
| GP Surgery |  |

| **Contact preference** |
| --- |
| Phone | Email | Face to Face | Post | Other:  |

# Carer/ Next of Kin Details

| Full Name: |  |
| --- | --- |
| Relationship: |  |
| Contact Details: |  |

| **Living with Dementia & Diagnosis**  |  | Actions Yes/No |
| --- | --- | --- |
| Carers Support/information required☐LPA in place ☐Benefits discussed inc. Council Tax ☐ |  |  |
| **Accessibility, Safety & Home Environment** |  | Actions Yes/No |
| Occupational Therapy/Physio Referral required ☐Living Aids/Assistive technology required ☐ |  |  |
| **Support in Place & Connections** |  | Actions Yes/No |
| Adult Social Care referral ☐SALT Referral required ☐ |  |  |
| **Crisis Prevention / Immediate Practical Needs** |  | ActionsYes/No |
| Employment support required ☐ Escalation to PCDP  |  |  |

# Information Sharing Consent

| Do you consent to us passing on your details where we have identified a need for a referral for specialist support?  | Yes☐ | No☐ |
| --- | --- | --- |
| Would you like a copy of your Care and Support Plan? | Yes☐ | No☐ |
| Note: Your data may be stored for up to 6 years |



**Date:**

|  |
| --- |
| **My Dementia Advisor** |
| Name: Contact Tel Number: |

|  |  |
| --- | --- |

# Care and Support Plan – Outcomes

| **Today we have discussed…** |
| --- |
|  |
| **What we do next….** |
|  |
| **Things to discuss next time.**  |
|  |

**Your Dementia Advisor will contact you in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you need assistance before your next review with a Dementia issue,**

**please contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(during office hours)**

If you need medical assistance, please contact your GP or 111.