Holt & District Dementia Support

Home Visiting Service - Referral Form

Name of person: ……... D.O.B. ……

Name of principal carer: ……

Address: ……

……

Tel. No: …… Mobile No: ……

Relevant Medical condition/s: ……

……

Mental Health condition: ……

……

Name of G.P: ……Medical Practice: ……

Referred by: …… Date of referral: ……

Please send completed form by post or email to the Home Visiting Service Coordinator –

Mrs. Eleanor Sidgwick

Address: The Cedars, 39 Cromer Road, Holt NR25 6EU

Tel. No: 01263 710617 or Email: emsidgwick@gmail.com

1. I consent to my personal details being disclosed to Holt & District Dementia Support for the purpose of accessing the Home Visiting Service and I understand that these details will be kept securely and deleted when I no longer access the service in accordance with the General Data Protection Regulation 2016:

Name: …… Signature: …… Date: ……

2. I consent on behalf of …… for his /her personal details to be disclosed to Holt & District Dementia Support for the purpose of accessing the Home Visiting Service and I understand that these details will be kept securely and deleted when …… is no longer accessing the service in accordance with the General Data Protection Regulation 2016. I confirm I am acting in accordance with my responsibilities as Lasting Power of Attorney:

Name: …… Signature: …… Date: ……..