**DEMENTIA CARE REFERRAL**

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| Client name: | Client number |  |
| DOB: | Fund source | ☐ Private☐ Other: |
| DOA: |
| Gender: M/F | Aboriginal/Torres Strait Islander: Y/N |
| Telephone number: |  |  |
| Current address: | Accommodation type (e.g., home, private rental): |
| **Team contacts** |
| **REFERRER DETAILS - Include Name, and Contact Number and email** |  |
| Next of Kin |  |
| Doctor |  |
| Cardiologist |  |
| Neuro-Psychologist |  |
| Dietician |  |
| Physiotherapist/Occupational Therapist |  |
| Guardian  |  |
| Administrator (Incl Ref) |  |
| Other  |  |

CCS (Dementia Care) REFERRAL FORM

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| **Referral information** |
| Medical issues/disabilities (e.g., ABI, W/C bound, 24hr care) |  |
| Risks for client (e.g., falls, alcohol/drugs, behaviour, mental health, general health)Please include any risk to carer attending property.  |  |
| Specific care needs / Personal Care (e.g., hygiene, incontinence) |  |
| Current Barriers / Issues  |  |
| **Supporting documents Provided** ☐ Neuro report ☐ Medical Report ☐ Medication Information ☐ Other  |  |

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| REASONS FOR CARE Details of Referral – (please comment on urgency) |
| OFFICE USE ONLYDate Referal received - Date Allocated - |