**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 ONLY  Date Referal received -  Date Allocated - |