Cognitive Dementia and Memory Service (CDAMS) Referral Form

South West Healthcare

Date of referral: _____

****Has the client consented to the service AND involvement of their NOK/Carer?** **YES** ☐

CLIENT INFORMATION			
Name:			**DOB:**
Address:			
Phone:			
Preferred spoken language:			**Is an interpreter required? Y / N**
Hearing status:	Adequate for assessment	Y / N	Hearing aids? Y / N
Vision status:	Adequate for assessment	Y / N	Glasses? Y / N
Current living situation:			
NOK/CARER INFORMATION			
Name:			
Relationship to patient:			
Phone:			
Main contact for referral:	**[ ] Patient**		**[ ] NOK/Carer**
MAIN SYMPTOMS & PROGRESSION (including behavioural/psychological symptoms)			
MEDICAL AND PSYCHIATRIC HISTORY (include substance use)			
FAMILY HISTORY			
RISK ASSESSMENT (please tick as applicable)			
[ ] Safety concerns in current living situation (for client or NOK/carer)			
[ ] Suspected self-neglect or abuse			
[ ] Client is a carer			
[ ] Rapid cognitive decline			
[ ] Significant carer burden and stress			
[ ] Other safety concerns (e.g. driving, depression symptoms) _____			
[ ] Young onset dementia is suspected			
INVESTIGATION CHECKLIST* (must be <12 months old at time of referral and ideally <3 months)			
[ ] Current medications (please attach list)			
[ ] MMSE (please attach completed test form)			
[ ] CT/MRI Brain			
[ ] Path results (**FBE, ESR, U&E, LFTs, TFTs Ca+, B12, Folate, Random BGL/HbA1c)** Consider also Syphilis and HIV serology if clinically indicated.			
***Referrals will not be processed until all investigations are received**			

Referring Doctor: _____ Signature: _____

Clinic Name: _____ Phone: _____

Phone: (03) 5563 4000 **Mob:** 0403 176 089 **Fax:** (03) 5563 1669 **Email:** intake@swh.net.au

Post: CDAMS, SWH Community Health Centre, Koroit Street, Warrnambool 3280