DEMENTIA CARE SUPPORT SERVICES

Please email completed referral form to: central@alzheimersotago.org.nz

ALZHEIMERS OTAGO - CENTRAL OTAGO OFFICE

Covering Central/Lakes including Alexandra, Cromwell, Wanaka, Ranfurly, Roxburgh

Alexandra Community House, 14-20 Centennial Ave, Alexandra 9340 Phone 03 448 9056 Mobile 027 441 4077

HAS A MEDICAL DIAGNOSIS OF DEMENTIA BEEN CONFIRMED? ☐Yes ☐ No **Diagnosed by:** Click or tap here to enter text. **Date of Diagnosis:** Click or tap to enter a date. **Method**: ☐ MOCA ☐ ACEIII Result: Click or tap here to enter text. *(please attach a copy of MOCA/ACE results)*	
Stage/level of dementia	☐ Early onset ☐ Mild ☒ Moderate ☐ Severe
Does the client live alone?	☐ Yes ☐ No

REFERRAL – WHO ARE YOU REFERRING? Who do you want us to make initial contact with?	
Caregiver	☐ Yes ☐ No
Person with dementia	☐ Yes ☐ No
Caregiver and person with dementia (both)	☐ Yes ☐ No

Please provide information for all people being referred to our services

CLIENT INFORMATION					
Title		**First names**			
Surname			**Preferred name**		
Residential address					
Region		**City**		**Post code**	
Landline		**Mobile**			
Date of birth	Click or tap to enter a date.	**NHI**		**Ethnicity**	
Communication requirements (i.e. glasses, hearing aids etc.)					

Client's GP		**GP phone**	
Practice details			
Email			

Client's carer/preferred contact person			
Name		**Relationship to client**	
Address			
Landline		**Mobile**	
Carer stress level	☐ Low ☐ Medium ☐ High ☐ Severe		

Does the client have an EPOA?	☐ Yes ☐ No	☐ Active ☐ Not active ☐ Unknown	
Name		**Relationship to client**	
Landline		**Mobile**	

INFORMATION TO ASSIST US TO PRIORITISE SUPPORT SERVICES					
Identify any immediate risk and/or safety concerns (to client, carer or public)					
Based on how the client presents, do you have concerns regarding their ADLS?					
Personal care/hygiene	☐	Weight loss/gain	☐	Medication management	☐
Continence	☐	Alcohol/drug usage	☐	Self-harm/suicidality	☐
Inappropriate behaviours	☐	Aggression/violence	☐	Hallucinations	☐
Wandering	☐	Mobility/Falls	☐	Sleep disturbance	☐
Please provide additional comments that may help us prioritise this client:					

Is the client still driving and licensed to drive?	☐ Yes ☐ No
Additional comments:	

Does the client receive home support services?	☐ Yes ☐ No *If available, please attach Care Plan*
Service provider details	

Is the client under MHSOP case management?	☐ Yes ☐ No		
Case Manager's name		**Referral date**	Click or tap to enter a date.

CONSENTS		
☐ I have made the client aware, that by making this referral, the client's relevant health information will be shared with Alzheimers Otago. Relevant healthcare information may include information about medical and mental health needs, social needs and support. Only information that the referrer feels would help Alzheimers Otago provide the best support for the client will be shared.		
The **client** agrees to the referral	☐ Yes	☐ No
The **client's preferred contact** agrees to the referral	☐ Yes	☐ No

Referrer Name		**Role**	
Organisation			
Phone		**Date**	Click or tap to enter a date.
Signature			