# DEMENTIA CARE SUPPORT SERVICES

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

**ALZHEIMERS OTAGO - NORTH OTAGO OFFICE**

27 Coquet Street, Oamaru    Phone: 03 434 9090    Mobile: 027 441 4022

**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 | | | |