

# DEMENTIA CARE SUPPORT SERVICES

Please email completed referral form to: [queenstown@alzheimersotago.org.nz](mailto:queenstown@alzheimersotago.org.nz)



## ALZHEIMERS OTAGO - QUEENSTOWN OFFICE

Covering Queenstown/Wanaka Lakes

Suite 129c, Aurum House, Frankton, Queenstown

Phone 03 441 4955

Mobile: 027 441 4960

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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person with dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver and person with dementia (both)	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<small>Click or tap to enter a date.</small>	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	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Severe

<b>Does the client have an EPOA?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active <input type="checkbox"/> Not active <input type="checkbox"/> Unknown
<b>Name</b>		<b>Relationship to client</b>
<b>Landline</b>		<b>Mobile</b>

### INFORMATION TO ASSIST US TO PRIORITISE SUPPORT SERVICES

**Identify any immediate risk and/or safety concerns (to client, carer or public)**

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**Based on how the client presents, do you have concerns regarding their ADLS?**

Personal care/hygiene	<input type="checkbox"/>	Weight loss/gain	<input type="checkbox"/>	Medication management	<input type="checkbox"/>
Continence	<input type="checkbox"/>	Alcohol/drug usage	<input type="checkbox"/>	Self-harm/suicidality	<input type="checkbox"/>
Inappropriate behaviours	<input type="checkbox"/>	Aggression/violence	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>
Wandering	<input type="checkbox"/>	Mobility/Falls	<input type="checkbox"/>	Sleep disturbance	<input type="checkbox"/>

***Please provide additional comments that may help us prioritise this client:***

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<b>Is the client still driving and licensed to drive?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Additional comments:</b>	

<b>Does the client receive home support services?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If available, please attach Care Plan</i>
<b>Service provider details</b>	

<b>Is the client under MHSOP case management?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Case Manager's name</b>		<b>Referral date</b>	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 <b>client</b> agrees to the referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The <b>client's preferred contact</b> agrees to the referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Referrer Name</b>		<b>Role</b>	
<b>Organisation</b>			
<b>Phone</b>		<b>Date</b>	Click or tap to enter a date.
<b>Signature</b>			