DEMENTIA REFERRAL

Referral to: Dementia Auckland
Complete an online referral form on our website – **www.dementiaauckland.org.nz**
Email to **info@dementiaauckland.org.nz** or **Fax: 636 0540**
Post to: **Dementia Auckland - P O Box 5132, Victoria St West, Auckland 1142**

* Mandatory Fields

1 Referrer Details

Services offered
- Information on dementia
- Keyworker support / navigation
- Education courses for carers / families
- Phone consultations
- Support groups for carers
- Activity groups for person with mild to moderate dementia

*__Date sent__ ____ / ____ / ____ *__From__ (name) _____

*__Contact Details:__ *Phone _____ *Email _____
*__Organisation__ ☐ Memory Clinic ☐ NASC ☐ Other - specify _____
☐ GP ☐ Specialist ☐ Geriatric Services ☐ MHSOP

☐ *__Auckland District Health Board__ ☐ *__Waitemata District Health Board__ ☐ *__Counties Manukau District Health Board__

2 Reason for referral

_____

_____

_____

3 Person living with dementia details or patient label

*First Names _____ (Preferred Name) _____
*Last Name _____
*Address _____
_____ *Post Code _____
Phone Number ( ) _____
Gender ☐ Male ☐ Female *Ethnicity _____
Age _____ *D.O.B _____ *NHI Number _____
*Diagnosis (type of dementia) _____
*Recent cognitive test results Date: ___/___/___ Score: _____ Test: _____

4 Carer details

*First Names _____ *Last Name _____
*Ethnicity _____ DOB ___/___/___
*Address _____
_____ *Post Code _____
*Relationship to person with dementia _____ *Email _____
*Phone Number Home ( ) _____ Work ( ) _____ Mobile _____

5 Other relevant information

_____

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_____

*__Consent given__ ☐ Yes ☐ No Date received by Dementia Auckland ___/___/___