Central Coast
Local Health District

Facility: COM GOS LJ WW WYG

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. DD / MM / YYYY	M.O.
ADDRESS	
	PH
M/C	FIN
LOCATION / WARD	ADM DD / MM / YYYY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REFERRAL – DEMENTIA SERVICES

COR5145

This is a Specialist Community Dementia Service. All referrals are triaged on acceptance. Please attach a medical history OR current health summary with the referral. Please fax the referral to: **CHAI via Fax 4320 9333**
For assistance please phone **1300 725 565** or email **CCLHD-CommunityHealthReferrals@health.nsw.gov.au**

Please tick the program you are referring the patient to:		Main Reason for Referral
☐ **Dementia Care Assessment**	Person centered assessment and care planning for the person living with dementia at home.	
☐ **Dementia Palliative Care Coordinator**	Community coordination of treatment, education, and enhanced end of life care for people with advanced dementia in the community.	
☐ **Memory Screening Assessment -** *Doctor or Specialist Referral Required*	Community based cognitive screening and reports.	
☐ **Carer Support**	Information, education, referral, and support. Monthly carer support groups at varied sites.	
☐ **Behaviour Assessment -** *Moderate to severe behaviour changes related to Dementia diagnosis*	Individualised behaviour strategies and care planning for people at home, RACF and in hospital.	

Client/Authorised representative is aware of the referral? ☐ Yes ☐ No Date: __ / __ / ____

Does the patient have any special needs (e.g. interpreter, liaison officers etc). If yes, detail below:

Referred by (print name) .....

Phone ..... Relationship to Client or organisation .....

Person to Contact 1 (The person you nominate to be your primary contact)

Given Name ..... Family Name .....

Relationship to Patient .....

Address ..... ☐ Same as Patient

Home phone ..... Mobile .....

Treating Clinician(s)

General Practitioner name .....

Surgery/Practice name ..... Phone .....

Email ..... or Fax .....

Specialist Doctor name .....

Specialty ..... Phone .....

Email ..... or Fax .....

This form was completed by:

Name ..... Signature .....

Designation ..... Date: __ / __ / ____

Contact phone .....

Holes punched as per AS2828.1:2019
BINDING MARGIN – NO WRITING

CATALOGUE NUMBER CC11719B-E JUN25/V5

REFERRAL – DEMENTIA SERVICES