Dementia Hawkes Bay™

REFERRAL FORM (001)

Please email completed form to: admin@dementiahb.org.nz

REFERRER DETAILS:

Name:			
Organisation:		Date of Referral	
Phone:		☐ Urgent:	☐ Non Urgent:
Email:			
Address:			
Consent	Client has consented for the referral to Dementia Hawkes Bay	☐ Yes	■ No

CLIENT DETAILS:

Name:			
NHI Number:		Location for Referral:	☐ Hastings ☐ Napier
DOB:		Ethnicity:	
Phone:		Mobile:	
Email:			
Address:			

SUPPORTING PARTNER:

Name:	
Relationship:	
Phone:	
Email:	
Address:	

REASON FOR REFERRAL AND SUPPORTS REQUESTED:

☐ Community Team ☐ Carer Support/Education	☐ Active Brain Programme ☐ Cognitive Stimulation Workshop

Details:

RELEVANT MEDICAL HISTORY:

Please include recent cognitive assessment results and details regarding a diagnosis of Dementia:

SOCIAL SITUATION: