CLIENT REFERRAL FORM

PERSON WITH DEMENTIA:							
Surname				**First Name**			
Address							
						NHI #	
Telephone		**Cell**		**Lives Alone**	Yes / No		
DOB		**Age**		**Email**			
Gender	Male ❒ Female ❒	**Ethnicity**		**Language**		Interpreter Required ❒	
Initial Contact: PWD ❒ Carer ❒ Family ❒ Other ❒							

CARER CONTACT:							
Surname				**First Name**			
Address							
Telephone		**Cell**		**Email:**			
DOB/Age		**Relationship to client:**					
Gender	Male ❒ Female ❒	**Ethnicity**		**Language**		Interpreter Required ❒	

FAMILY CONTACT:				
Telephone		**Cell**		**Email:**

DIAGNOSIS: **BY WHOM:**

Priority	**High**	**Moderate**	**Non-Urgent**

Consent - Client/Support person is aware of / Agrees to referral	Yes / No	**GP:**	**Phone:**
Carer Stress	Yes / No	**Safety** (please explain):	Yes / No
Social Isolation	Yes / No	**Total Mobility Card** (Taxi Vouchers)	Yes / No
Groups	Yes / No	**Education:** PWD ❒ Carer ❒ Family ❒	
EPOA: Welfare	Yes / No	**Name:**	
Finance/Property	Yes / No	**Name:**	

Other Agencies Involved	

Other relevant information: **(Please use second page if necessary or attach Care Plan etc)**

REFERRER:			
Name		**Position**	
Organisation		**Telephone**	
Date		**Email Address**	

EMAIL: admin@dementiacanterbury.org.nz ~ FAX: (03) 379 7286 ~ POST: P O Box 20567, Christchurch

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