A partnership led by HammondCare

DBMAS Referral in form

Date: ____/_____/_____

Consent given to gather information (Signed or Verbal): ☐ Yes ☐ No

Name of relevant person or Guardian giving consent: ________________________________

Referrer's Details (Your Name / Organisation):	
☐ Client ☐ Provider ☐ Contact ☐ Dr/Organisation	
Organisation Name:	
Referrer's Contact Name:	
Preferred Contact Number / Fax:	
Email:	
Facility Manager Name & Contact number:	
Details of Other Services receiving this referral:	

Relevant Person Contact Details (e.g. Guardian):	
Full name:	
Preferred Contact Number:	
Email:	

Person with dementia:			
Given name:			
Surname:			
Address:			
Suburb:			
State:		Post code:	
Preferred Contact No:		Mobile:	
Email:			
Date of Birth:		Sex (Male/Female):	
Services received:	☐ Community	☐ Aged Care Facility	☐ Other- see next page
Admission Date:			

Type of dementia:		
☐ Alzheimer's Disease	☐ Vascular Dementia	☐ FLTD
☐ Lewy Body	☐ Alcohol related	☐ Huntington's
☐ Parkinson's	☐ Not stated	☐ HIV
☐ Mixed	☐ Other: ____________	
Date of Dementia Diagnosis:___/___/___	Dementia Diagnosis Confirmed: ☐ Yes ☐ No	
Severity of dementia:		

Phone: 1800 699 799 **Fax:** 1800 921 223
Email: dsa@dementia.com.au
www.dbmas.org.au

Funded by the Australian Government

☐ Suspected	☐ Mild	☐ Moderate	☐Severe	☐None	☐Unknown
Special Needs:					
☐ ATSI	☐ LGBTI	☐ Care leavers	☐ Rural/ remote area	☐ CALD	
☐ Homeless	☐ At risk of homelessness	☐ Financially disadvantaged			
☐ Younger Onset					
☐ Person with dementia living alone	☐ Unknown				
Interpreter Required: ☐ Yes ☐ No Details: ________________________________					

Reason for Referral/ Description of Behaviours of Concern:

Expected Outcomes

Other People/Services involved:

Relationship	Name	Phone number Fax number	Email
GP			

Attachment Checklist:
☐ Medication Chart
☐ Medical History
☐ Relevant Notes