

## Health Professional Referral

General Practitioner (GP) Name:.....  
 Address: .....  
 Phone No: .....Fax No: .....  
 Is GP aware of referral? Yes/No

Patient Name:.....

Patient Address: :.....

Patient Phone:.....Patient DOB: .....

1. Does this patient have a diagnosis relating to memory loss? Yes / No
2. Current diagnoses.....
3. Please attach a current **health summary**.
4. Does the patient have the following symptoms (please circle)
  - **Cognitive change** e.g. Memory Loss, Aphasia, Apraxia, Agnosia, Disturbance in Planning & Organising other?.....
  - **Behavioural and Psychiatric symptoms** e.g. Anxiety, Agitation, Depression, Disinhibited, Shadowing & Wandering other?.....
  - **Decline in activities of daily living** e.g. Banking, shopping, personal hygiene, cooking, toileting, communicating other?.....

If you have tested for arrestable causes of cognitive impairment - **please attach result:** e.g. TFT, Vit D, Vit B12, Folate, FBC, U's&E's, Fasting Glucose (or HbA1c if diabetic), (CT scan - if one has been completed within the last 24 months)

Do you judge the severity of these symptoms to be:      **Mild    Moderate    Severe**

**Name, Profession and Signature:** .....

**The clinic will provide:**

- Cognitive Screening                      ■ Assessment                      ■ Support Service Review
- Planning Ahead Information e.g. Advance Care Directives, Enduring Guardianship etc

**Please tick other issues you would like discussed:**

- Behaviour Management       Carer support                       Driving
- Residential Care                       Medications                       Other?.....

Is there anything in particular you **don't want** us to discuss?.....

**Fax Referral to 03 6230 7542**