Western Health Cognitive, Dementia and Memory Service (CDAMS) – Footscray Hospital Referral Guidelines

Western Health

CDAMS is a specialist **diagnostic** clinic for people with memory or cognitive changes who **do not have a diagnosis**.

Please review these guidelines before referring to CDAMS to ensure the referral meets eligibility criteria. Referrals with insufficient information will be returned with a request for additional information which may delay access to this service. If you have any questions please **contact 8345 7865**.

Services Provided

- Expert clinical diagnosis.
- Information on appropriate treatments.
- Education, support and information.
- Direction in future planning.
- Information/advice on dealing with day to day issues.
- Referrals for clients/family/ carers to service providers or community supports.

An initial assessment is completed by allied health or nursing staff approx. 8 weeks from receipt of referral.

This is followed by an assessment with medical or other allied health staff approx. 8-12 weeks after initial assessment.

Eligibility Criteria

- > 50 years with **early symptoms of cognitive impairment** who do not have a diagnosis.
- Symptoms present **for a minimum of 6 months.**
- < 50 years with early symptoms of cognitive impairment or family history of dementia. See exclusion criteria if mood issues present.
- Have an early diagnosis but are seeking second opinion.
- Reside in Brimbank, Hobson's Bay, Maribyrnong, Wyndham and Melton.
- NB. Persons with long standing ABI/Intellectual impairment are **not eligible unless** there has been an **unrelated deterioration** in cognitive functioning which might indicate a neurodegenerative process.

Exclusion Criteria

- **Recent onset** of cognitive decline (days/weeks) - need to consider delirium/stroke which requires urgent medical assessment – **refer to ED.**
- **Complex psychiatric conditions** who may also have cognitive changes.
  If > 65 years refer to APATT; if < 65 refer to Neuropsychiatry Dept. RMH.
- **Current heavy alcohol intake.**
  Referrals accepted if client alcohol free 3 – 4 months.
- **< 50 years complaining of memory problems in context of stress, anxiety, depression** or where other **psychiatric conditions may be the cause.**
  Refer firstly to psychiatrist or private physician to exclude these factors as cause.
  Referrals will be accepted once these factors have been excluded by relevant specialist.
- **Diagnosis already confirmed.**
  E.g. Dementia, Huntington's ABI, Stroke, postictal etc. and under care of private neurologist or psychiatrist.
- **Diagnosis known but needs community supports /counselling.**
  Refer to AAV, Carers Links West, My Aged Care, NDIS.
- **Dementia diagnosis known but has behavioural or psychological disturbance.**
  Refer to APATT.
- **Neuropsychological or capacity assessment only** – refer to private provider
- **In Residential Care** – refer to private provider.
- **Moderate to advanced symptoms.**
  E.g. Geographical disorientation within home, prompting or assistance to complete tasks, neglecting self or nutrition, safety risk - refer to ACAS via My Aged Care.
- **Physically unable** to attend/**poor endurance,** due to length of sessions.

Referral Requirements

Please fax referrals to 8345 6394.
Referrals must include:

- Client demographics.
- Relevant medical and surgical history.
- Current medications.
- Relevant investigations.
- Other services/specialists involved in care.
- Interpreter requirements.
- Referral reason.
- Investigation results as below.

Required Investigations:
The following must be completed and results attached to referral. Referrals cannot be accepted otherwise.

- **Radiology** – CT brain.
- **Pathology** – FBE, ESR, Urea, Creatinine, Electrolytes, Vitamin B12, Liver Function Tests, Folate , Thyroid Function Tests, Random Blood Glucose, Calcium, Cholesterol, Syphilis Serology.
- **MSU.**
- **ECG.**

Key contact information:

Dementia Aust Vic – 1800 100 500.

My Aged Care – 1800 200 422.

Neuropsychiatry Dept, RMH – 9342 8750.

Aged Psychiatry Assessment & Treatment Team (APATT) – 1300 874 243.

Adult Mental Health Services (Under 65 yrs of age) – 1300 859 764.

ABI Service, Western Region – 9449 6931.

Intellectual Disability Service (Includes the Behaviour Intervention Support Team for persons with both an Intellectual and Psychiatric disability) – Intake 9412 2741.

Western Health

Western Cognitive, Dementia & Memory Service Referral Form (CDAMS)

Referral Date:___/___/____

UR							

Footscray Hospital: 160 Gordon St, Footscray Victoria 3011
Telephone: 8345 1355 Fax: 8345 6394

Surname:

Given Names:

Address:

Suburb: **Postcode:**

Telephone: **Mobile:**

Sex: ☐ M ☐ F ☐ Intersex **Date of Birth:**

Marital status: ☐ Single ☐ Married ☐ Defacto ☐ Widowed ☐ Separated ☐ Divorced

Birthplace (MDS)	**Indigenous status:**
☐ Australia:	☐ Indigenous – Aboriginal but **not** Torres Strait Islander
☐ Other (List):	☐ Indigenous – Torres Strait Islander but **not** Aboriginal
Preferred language	☐ Indigenous – Aboriginal and Torres Strait Islander
☐ English ☐ Other	☐ Not indigenous – Aboriginal or Torres Strait Islander
Interpreter required	☐ Questions unable to be answered
☐ Yes ☐ No ☐ Not stated	

GP/LMO: ______________________ **Phone** ______________
Address: **Postcode** ________

Consent: Is the Client aware of this referral? ☐ Yes ☐ No
Client/Nominated carer agrees to CDAMS contacting GP for health information prior to first Assessment ☐ Yes ☐ No

Contact 1:	**Contact 2:**
Name: ______________	**Name:** ______________
Relationship to Client: ______________	**Relationship to Client:** ______________
Address: ______________	**Address:** ______________
Phone: Home: ______________	**Phone: Home:** ______________
Mobile: ______________	**Mobile:** ______________

Appointment: Who do we contact to make an appointment? ☐ **Client** ☐ **Contact 1** ☐ **Contact 2**

Referrers Name: ______________________ **Relationship to client:** ______________
Address / Western Health Dept: ______________________
Telephone: (H) **(W)** **(Mobile)**

Reason For Referral: (NB Onset of memory/cognitive problems must be greater than 6 months)

S

B

A

R

Please complete section on next page– medical Hx etc.

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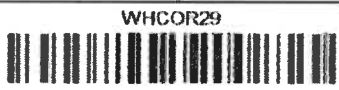

Medical History: B

Psychiatric History:

Any Risks to Staff/Client:

Current Medications:

Current / Previous Contact with: B

- ☐ Geriatrician
- ☐ Neurologist
- ☐ Psychiatrist
- ☐ Other Medical Specialist
- ☐ Aged Care Assessment Service
- ☐ Aged Psychiatry Ax Team / Adult Mental Health
- ☐ Other relevant Services

Previous Cognitive Assessment Completed?

☐ Yes ☐ No

If Yes by Whom and When:

Carer Availability	**Carer Relationship**	**Living Arrangements**	**Usual Accommodation**
No Carer	☐ Spouse/Partner	☐ Lives Alone	☐ Priv Res. Owned/ Purchasing/ Rental
☐ Co-resident Carer	☐ Parent	☐ Lives with Family	☐ Short term crisis/Emergency Facility
☐ Non Resident Carer	☐ Child	☐ Lives with Others	☐ Residential Aged Care Facility
	☐ Child-in-law	☐ Not stated/not adequately described	☐ Public place, Homeless
	☐ Other Relative		☐ Independent Unit Retirement Village
I	☐ Friend/Neighbour		☐ Not stated/not adequately described

Medicare No:

DVA No: (if applicable)

TAC ☐Yes ☐ No Claim Number:

Workcover ☐ Yes ☐No Claim Number

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