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

Western Health

Referral Date:___/___/____

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Footscray Hospital: 160 Gordon St, Footscray Victoria 3011
Telephone: 8345 1355 Fax: 8345 6394 Email: WH-CDAMS@wh.org.au

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)
☐ Australia:
☐ Other (List): _____

Preferred language
☐ English ☐ Other _____

Interpreter required
☐ Yes ☐ No ☐ Not stated

Indigenous status:
☐ Indigenous – Aboriginal but **not** Torres Strait Islander
☐ Indigenous – Torres Strait Islander but **not** Aboriginal
☐ Indigenous – Aboriginal and Torres Strait Islander
☐ Not indigenous – Aboriginal or Torres Strait Islander
☐ Questions unable to be answered

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:
Name: _____
Relationship to Client: _____
Address: _____
_____
Phone: Home: _____
Mobile: _____

Contact 2:
Name: _____
Relationship to Client: _____
Address: _____
_____
Phone: Home: _____
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.

B

Medical History:

Current Medications:

Psychiatric History:

Any Risks to Staff/Client:

B

Current / Previous Contact with:

- ☐ 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:

I

Carer Availability	**Carer Relationship**	**Living Arrangements**	**Accommodation**
☐ No Carer	☐ Spouse/Partner	☐ Lives Alone	☐ Private (own/rent/purchase)
☐ Co-resident Carer	☐ Parent	☐ Lives with Family	☐ Outreach
☐ Non Resident Carer	☐ Child	☐ Lives with Others	☐ Supported Community
	☐ Child-in-law	☐ Not stated	☐ Residential Aged Care
	☐ Other Relative		☐ Residential Care Facility (not aged)
	☐ Friend/Neighbour		☐ Short Term Crisis/Emergency
	☐ Foster Carer		☐ Other Accommodation

Medicare No:	TAC ☐ Yes ☐ No Claim Number:
DVA No: (if applicable)	Workcover ☐ Yes ☐ No Claim Number