Health
Hunter New England
Local Health District

HealthWISE
NEW ENGLAND NORTH WEST

MEMORY INVESTIGATION SERVICE

Referrer Information	
Date	
Name	
Organisation / Service	
Position / Provider Number	
Phone Number	
Reason for Referral	
Is client and family aware and **consent** to referral? ☐ Yes ☐ No	
Neuropsychology Referral: Is **capacity** assessment required? ☐ Yes ☐ No	
Has the patient been previously seen by any of the following Memory Investigation Services? **HNELHD** ☐ Yes ☐ No **HealthWISE** ☐ Yes ☐ No	
General Practitioners: Please also complete all sections of the document, over page.	

Patient Information	
Name	
Date of Birth	
Gender	☐ Male ☐ Female
Address	
Phone Number	Home: Work / Mobile:
Name of GP	
Does the patient identify as:	☐ Aboriginal, or ☐ Torres Strait Islander, or ☐ Aboriginal and Torres Strait Islander

Main Contact Information	
Name of Contact	
Relationship to Patient	
Address	
Phone Number	Home: Work / Mobile:

Please forward referral to <u>ONE</u> of the following services:

Hunter New England LHD
Cognition and Memory Service
Dementia Support Worker
Phone: 02 6721 9600
Fax: 02 6721 9580

CNC Dementia
Neuropsychologist
Phone: 02 6776 9600
Fax: 02 6776 9750

<u>OR</u>

HealthWISE
Memory Assessment Program (MAP)
MAP Coordinator

PO Box 1321, Armidale NSW 2350
Phone: 02 6771 1146
Fax: 02 6771 1170

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NSW GOVERNMENT

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Please complete all sections or attach relevant summaries from the patient's medical record

Past Medical History					
Alcoholism	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Head Injury	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Hyperlipidaemia	☐ Yes	☐ No	TIA	☐ Yes	☐ No
Other:					

Current Medications including vitamins, herbal remedies and over the counter medications

Health Checklist			
BP	/		
BMI	kg / m2		
Weight	kgs		
Height	cms		
Smoker	☐ Never	☐ Current	☐ Past > 3 months
Alcohol	Standard drinks per day		
Has the patient had a fall in the last 12 months?	☐ Yes	☐ No	

Mini-Mental State Examination (MMSE) - please attach copy		
Score	/ 30	
Clock Test: Ask the patient to draw a clock, with the numbers in their correct positions. Then ask the patient to draw the hands on the clock to indicate the time (i.e. 9:20).		
Patient draws a closed circle	☐ Yes	☐ No
Numbers correctly placed	☐ Yes	☐ No
All twelve (12) numbers included	☐ Yes	☐ No
Hands of clock placed in correct position	☐ Yes	☐ No
Total Score:	**/4**	

Investigation Checklist			
FBC / ESR	☐ Attached	Serum B12 / Folate	☐ Attached
BSL	☐ Attached	Urine MC&S	☐ Attached
LFT / EUC	☐ Attached	**ECG**	☐ Attached
Ca / Mg / Phosphate	☐ Attached	**Brain CT**	☐ Attached
Cholesterol	☐ Attached	CRP* / HIV* / VDRL* and/or Vit D*	☐ * Attach only if indicated
TFT	☐ Attached		

Geriatrician / Rehabilitation Physician / Psychogeriatrician (Old Age Psychiatrist) referral attached? ☐ Yes ☐ No

Neuropsychologist referral attached (as required)? ☐ Yes ☐ No

Is capacity assessment required? ☐ Yes ☐ No