

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Neuropsychology Referral: Is capacity assessment required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient been previously seen by any of the following Memory Investigation Services?	
HNELHD	<input type="checkbox"/> Yes <input type="checkbox"/> No
HealthWISE	<input type="checkbox"/> Yes <input type="checkbox"/> No
General Practitioners: Please also complete all sections of the document, over page.	

Patient Information	
Name	
Date of Birth	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	
Phone Number	Home: _____ Work / Mobile: _____
Name of GP	
Does the patient identify as:	<input type="checkbox"/> Aboriginal, or <input type="checkbox"/> Torres Strait Islander, or <input type="checkbox"/> Aboriginal and Torres Strait Islander

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

Please forward referral to the following service:

Hunter New England Local Health District	
Cognition and Memory Service	
Out-patient / community referral: CNC Psychogeriatrics	
In-patient referral only: CNC Dementia/Delirium (Acute Settings)	
Phone: 02 6767 8100 Fax: 02 6767 8080	
Neuropsychologist	
Phone: 02 6776 9600 Fax: 02 6776 9750	

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

Past Medical History					
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hyperlipidaemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other:					

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

Health Checklist	
BP	/
BMI	kg / m ²
Weight	kgs
Height	cms
Smoker	<input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past > 3 months
Alcohol	Standard drinks per day
Has the patient had a fall in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Numbers correctly placed	<input type="checkbox"/> Yes <input type="checkbox"/> No
All twelve (12) numbers included	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hands of clock placed in correct position	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total Score:	/4

Investigation Checklist			
FBC / ESR	<input type="checkbox"/> Attached	Serum B12 / Folate	<input type="checkbox"/> Attached
BSL	<input type="checkbox"/> Attached	Urine MC&S	<input type="checkbox"/> Attached
LFT / EUC	<input type="checkbox"/> Attached	ECG	<input type="checkbox"/> Attached
Ca / Mg / Phosphate	<input type="checkbox"/> Attached	Brain CT	<input type="checkbox"/> Attached
Cholesterol	<input type="checkbox"/> Attached	CRP* / HIV* /	<input type="checkbox"/> * Attach only if indicated
TFT	<input type="checkbox"/> Attached	VDRL* and/or Vit D*	
Geriatrician / Rehabilitation Physician / Psychogeriatrician (Old Age Psychiatrist) referral attached?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Neuropsychologist referral attached (as required)?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is capacity assessment required?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			