MEMORY INVESTIGATION SERVICE

Referrer Information	
Date	
Name	
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 **NEML or 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 General Practitioner		
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 the following service:

Hunter New England Local Health District
Tamworth Community Health
Phone: 02 6767 8100
Fax: 02 6767 8080

Out-patient / community referral
Julie Kensell – CNC Psychogeriatrics
Phone: 02 6767 8304 (Direct)

In-patient referral only
Kerry Coss – CNC Dementia / Delirium (Acute Settings)
Phone: 02 6767 8212 (Direct)

Health
Hunter New England
Local Health District

HealthWISE
NEW ENGLAND NORTH WEST

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**

☐ **Neuropsychologist referral attached (as required)**