Health
Hunter New England
Local Health District

HealthWISE
Mental Health · Allied Health · Aboriginal Health

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 the following service:

Hunter New England Local Health District
Cognition and Memory Service
Dementia Support – Clinical Nurse Specialist
Dementia Advisory Support
Phone: 02 6799 2800 **Fax: 02 6799 2919**

Neuropsychologist
Phone: 02 6776 9600 **Fax: 02 49236541**

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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