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 ONE of the following services:

Hunter New England LHD **Cognition and Memory Service** CNC Dementia Dementia Support Worker Neuropsychologist Phone: 02 6776 9600 **Fax: 02 49236541**	**OR** **HealthWISE** **Memory Assessment Program (MAP)** MAP Coordinator PO Box 1321, Armidale NSW 2350 Phone: 02 6771 1146 **Fax: 02 6771 1170** **Or via Medical Objects**

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* /	☐ * Attach only if
TFT	☐ Attached	VDRL* and/or Vit D*	indicated

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

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

Is capacity assessment required?   ☐ Yes   ☐ No