***CONFIDENTIAL***

**REFERRAL FOR YOUNG ONSET DEMENTIA CLINIC**

*The Young Onset Dementia Clinic is an assessment and clinical management program for patients with a diagnosed or strongly suspected young-onset dementia (age of onset below age 65). Referrals to this clinic are for Neurology review. If relevant to the clinical management, patients may subsequently also be eligible for input from Psychiatry, Social Work, Speech Pathology, and Clinical Neuropsychology.*

**Please complete form in Microsoft Word & return via email to:** [**Graylands.Neurosciences@health.wa.gov.au**](mailto:Graylands.Neurosciences@health.wa.gov.au)

*To complete the form, type directly into the highlighted grey box (you don’t need to click in the grey field or make the cursor appear) or click on the relevant boxes. Once you have completed the form you need to save the changes and email the saved document as an attachment*

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| **PATIENT’S DETAILS:** | | | | | | |
| Surname: |  | | First Name/s: | | |  |
| DOB: |  | | Gender: | | |  |
| Mobile Number: |  | | Home Number: | | |  |
| Address: |  | | | | | |
| Email Address: |  | |  | | |  |
| Language(s) spoken: |  | | Interpreter Required: Yes / No  Language: | | | |
| Is the client of | Aboriginal or | | | **Is the patient aware of this referral?**  Yes  No | | |
|  | Torres Strait Islander origin | | |
| **Best contact?** | Patient | Other: Name: | | |  | |
| Relationship: | | |  | |
| Phone: | | |  | |
| Email: | | |  | |
| Does the client have a Guardian for medical decision making?  OR an Enduring Power of Guardianship (EPG) with the function of medical decision making?  If an EPG, is this document currently in operation:  Yes  No | | No  Yes  Guardian/EPG Name:  Email:  Phone:  **Has the Guardian / Enduring Guardian with medical decision-making powers consented to this referral?**  Yes  No | | | | |
| **REASON FOR NEUROSCIENCES SERVICE (please complete all sections):** | | | | | | |
| Presenting problems (include duration, frequency, previous history): | | | | | | |
| What is the specific referral question/s? | | | | | | |
| How will the assessment help with the client’s management? | | | | | | |

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| **RELEVANT NEUROLOGICAL/MEDICAL/PSYCHOLOGICAL HISTORY:** |
| Any known relevant family history of dementia? |

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| **CURRENT MEDICATION REGIME AND INVESTIGATIONS:** | |
| Current dose(s): |  |
| Results of any CT, MRI, SPECT/PET, EEG, bloods, genetic testing, etc.: |  |
| *Please attach any available specialist letters of assessment or reports pertaining to the above investigations.* | |

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| **OTHER RELEVANT ISSUES:** | |
| Are there any medicolegal issues? | Yes  No |
| If yes, details: | |
| Is the client registered with NDIS?: | Yes  No, but is / will be applying  No |
| Are you aware of any current factors that may affect the client’s ability to participate in the assessment or put clinicians at risk (e.g., agitation, aggressive behaviours, OCD, physical limitations etc)?    Are there any other issues we should be aware of? (e.g., scheduled SAT hearing, patient going overseas, intended inpatient admission or discharge etc)? | |

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| **CURRENT AND PREVIOUS AGENCY/HEALTH PERSONNEL INVOLVEMENT (incl. GP):** | | | |
| Contact person & agency: |  | Contact Number |  |
| Contact person & agency: |  | Contact Number |  |
| Contact person & agency: |  | Contact Number |  |
| Are current agencies aware of this referral? | | Yes  No | |

|  |  |  |  |
| --- | --- | --- | --- |
| **REFERRER’S DETAILS:** | | | |
| Name: |  | Position: |  |
| If Registrar, Consultant: |  | Contact Number: |  |
| Agency: |  | Address: |  |
| Email: |  | | |
| Date: |  | | |

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| **Please call the Neurosciences Unit to check the current wait list.**  **If you are unsure if a referral is appropriate for our service, please contact NSU on 6159 6464.** |

**Please return this form via:**

Email (preferred): [**Graylands.Neurosciences@health.wa.gov.au**](mailto:Graylands.Neurosciences@health.wa.gov.au)

Fax: 9385 6813 or

Mail: Post Office Private Bag No.1 CLAREMONT WA 6910