General referral to Dementia Waikato.

Dementia Waikato™
Living well with dementia

Client Details:

Surname:		First names:	NHI:
Ethnicity:		DOB:	Gender:
Street Number & Name:			Phone: Cell:
Suburb:	City:		Email:

Care Partner:

Name:	Relationship:	Phone:
Address:		Email:

Who should Dementia Waikato contact in the first instance? ✓

☐Client ☐Care Partner ☐Other……..

Medical Information:

Diagnosis:	Date Diagnosed:	Diagnosing Clinician:
GP/Practice Name:		

Does the client live alone? ☐Yes ☐No	Does the client have EPOA? ☐ Yes ☐ No	If yes, has it been activated?
EPOA Name & Phone number:		
Reason for referral:		

Referrer Name:	Referrer role: (self, family, friend etc)	Referrer Service: (eg, Church, Lawyer, etc)
Referrer Phone / Email:		

I confirm that the client [Person with Dementia, Care Partner or EPOA] consents for referral:

Signature of Referrer: _____ DATE: _____

Email this to: referral@dementiawaikato.org.nz

Dementia Waikato: Ph 07 929 4042 Address: P.O. Box 5720, Hamilton, 3242