

Clinical referral to Dementia Waikato.



Living well with dementia

Client Details:

Patient sticker		NHI Full name, DOB Address Phone
Ethnicity:	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the client have EPOA? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, has it been activated?
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EPOA Name & Phone number:

Reason for referral:

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