

## MEMORY INVESTIGATION SERVICE

<b>Referrer Information</b>	
Date	
Name	
Organisation / Service	
Position / Provider Number	
Phone Number	
Reason for Referral	
Is client and family aware and <b>consent</b> to referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Neuropsychology Referral: Is <b>capacity</b> assessment required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient been previously seen by any of the following Memory Investigation Services?	
<b>HNELHD</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HealthWISE</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>General Practitioners: Please also complete all sections of the document, over page.</b>	

<b>Patient Information</b>	
Name	
Date of Birth	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	
Phone Number	Home: Work / Mobile:
Name of GP	
Does the patient identify as: <input type="checkbox"/> Aboriginal, or <input type="checkbox"/> Torres Strait Islander, or <input type="checkbox"/> Aboriginal and Torres Strait Islander	

<b>Main Contact Information</b>	
Name of Contact	
Relationship to Patient	
Address	
Phone Number	Home: Work / Mobile:

Please forward referral to **ONE** of the following services:

<p><b>Hunter New England LHD</b> <b>Cognition and Memory Service</b> Dementia Support Worker Phone: 02 6721 9600 <b>Fax: 02 6721 9580</b></p> <p>CNC Dementia Neuropsychologist Phone: 02 6776 9600 <b>Fax: 02 49236541</b></p>
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**OR**

<p><b>HealthWISE</b> <b>Memory Assessment Program (MAP)</b> MAP Coordinator</p> <p>PO Box 1321, Armidale NSW 2350 Phone: 02 6771 1146 <b>Fax: 02 6771 1170</b> <b>Or via Medical Objects</b></p>
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**Please complete all sections or attach relevant summaries from the patient's medical record**

<b>Past Medical History</b>					
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hyperlipidaemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other:					

<b>Current Medications</b> including vitamins, herbal remedies and over the counter medications

<b>Health Checklist</b>	
BP	/
BMI	kg / m2
Weight	kgs
Height	cms
Smoker	<input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past > 3 months
Alcohol	Standard drinks per day
Has the patient had a fall in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Mini-Mental State Examination (MMSE) - please attach copy</b>	
Score	/ 30
<b>Clock Test:</b> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Numbers correctly placed	<input type="checkbox"/> Yes <input type="checkbox"/> No
All twelve (12) numbers included	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hands of clock placed in correct position	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Total Score:</b>	<b>/4</b>

<b>Investigation Checklist</b>			
FBC / ESR	<input type="checkbox"/> Attached	Serum B12 / Folate	<input type="checkbox"/> Attached
BSL	<input type="checkbox"/> Attached	Urine MC&S	<input type="checkbox"/> Attached
LFT / EUC	<input type="checkbox"/> Attached	<b>ECG</b>	<input type="checkbox"/> Attached
Ca / Mg / Phosphate	<input type="checkbox"/> Attached	<b>Brain CT</b>	<input type="checkbox"/> Attached
Cholesterol	<input type="checkbox"/> Attached	CRP* / HIV* /	<input type="checkbox"/> * Attach only if indicated
TFT	<input type="checkbox"/> Attached	VDRL* and/or Vit D*	
<b>Geriatrician / Rehabilitation Physician / Psychogeriatrician (Old Age Psychiatrist) referral attached?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Neuropsychologist referral attached (as required)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Is capacity assessment required?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			