ALZHEIMER'S AND DEMENTIA AUSTRALIA AND HOPE
FIGHTDEMENTIA.ORG.AU

LIVING WITH MEMORY LOSS PROGRAM

External Referral Form Date .....

Please complete the details of any clients you feel may be suitable for the Living with Memory Loss Program, then e-mail or fax this form to the address below:

Key Contact Person:

N.B. It is essential that this person has given consent to be contacted by a representative of Alzheimer's Australia NSW.

Relationship to person with memory loss/dementia _____

First name _____ Surname _____

Street _____

Suburb/City _____ Postcode _____

Telephone (home) _____ Days/times _____

Telephone (work) _____ Days/times _____

Restrictions on contact _____

Person with memory loss/dementia:

N.B. This information is necessary to help determine program suitability.

First name _____ Surname _____

Street _____

Suburb/City _____ Postcode _____

Date of birth ___ / ___ / ___ or Age ___ years Male Female

Telephone (home) _____ (work) _____

Telephone (work) _____ Days/times _____

Type of dementia (if diagnosed) _____

Diagnosed by _____ Approx. date _____

Referred by:

N.B. This information enables us to provide feedback about your referral

Relationship to person with memory loss/dementia _____

First name _____ Surname _____

Role _____

Organisation _____ Phone _____

Street _____

Suburb/City _____ Postcode _____

I would like feedback regarding this referral: ☐ **YES** ☐ **NO**

Please return to: Living with Memory Loss Team
F: 8875 4665
E: NSW.referralearlyintervention@alzheimers.org.au
T: 1800 100 500
Alzheimer's Australia PO Box 6042 North Ryde NSW 2113