Client Referral Form

SRVS.005 – Form 2

FIGHT ALZHEIMER'S SAVE AUSTRALIA
FIGHTDEMENTIA.ORG.AU

This form is to be completed by the referee. Once fully completed, please either:

Fax to: **8338 3390** Email scanned copy to: **sa.linkworkers@alzheimers.org.au**

Has the referred person and/or carer given permission for this referral. ☐ **Yes** ☐ **No**
If NO, then this referral can not proceed.

REFEREE	
Name:	
Organisation eg Hospital, GP Practice:	
Address:	
Telephone:	Referral Date: / /

CLIENT / PERSON BEING REFERRED	
Name:	
Address:	
Telephone:	Date of birth:

CARER / CONTACT	
Name:	
Relationship to Client:	
Address:	
Telephone:	
Who is the first point of contact:	
Can a message be left: ☐ Yes ☐ No	
Has the person been medically diagnosed with dementia: ☐ Yes ☐ No	
If yes, date of diagnosis: / /	Type:

Reason for referral (eg in home support, respite, information/eduction :

Any outcomes expected discussed:

Information collected will be reported and stored in accordance with the Privacy Act 1988 and the Australian Privacy Principles 2014. Information will not be shared with a third party without your prior consent.

Should you require any further information relating to the privacy of your information, please refer to the Alzheimer's Australia SA Privacy Policy available on our website www.fightdementia.org.au/sa or contact our Privacy Officer on 08 8372 2100.

OFFICE USE ONLY: Entered onto database Date: _____ Initial: _____
Transferred onto Client Assessment Form Date: _____ Initial: _____