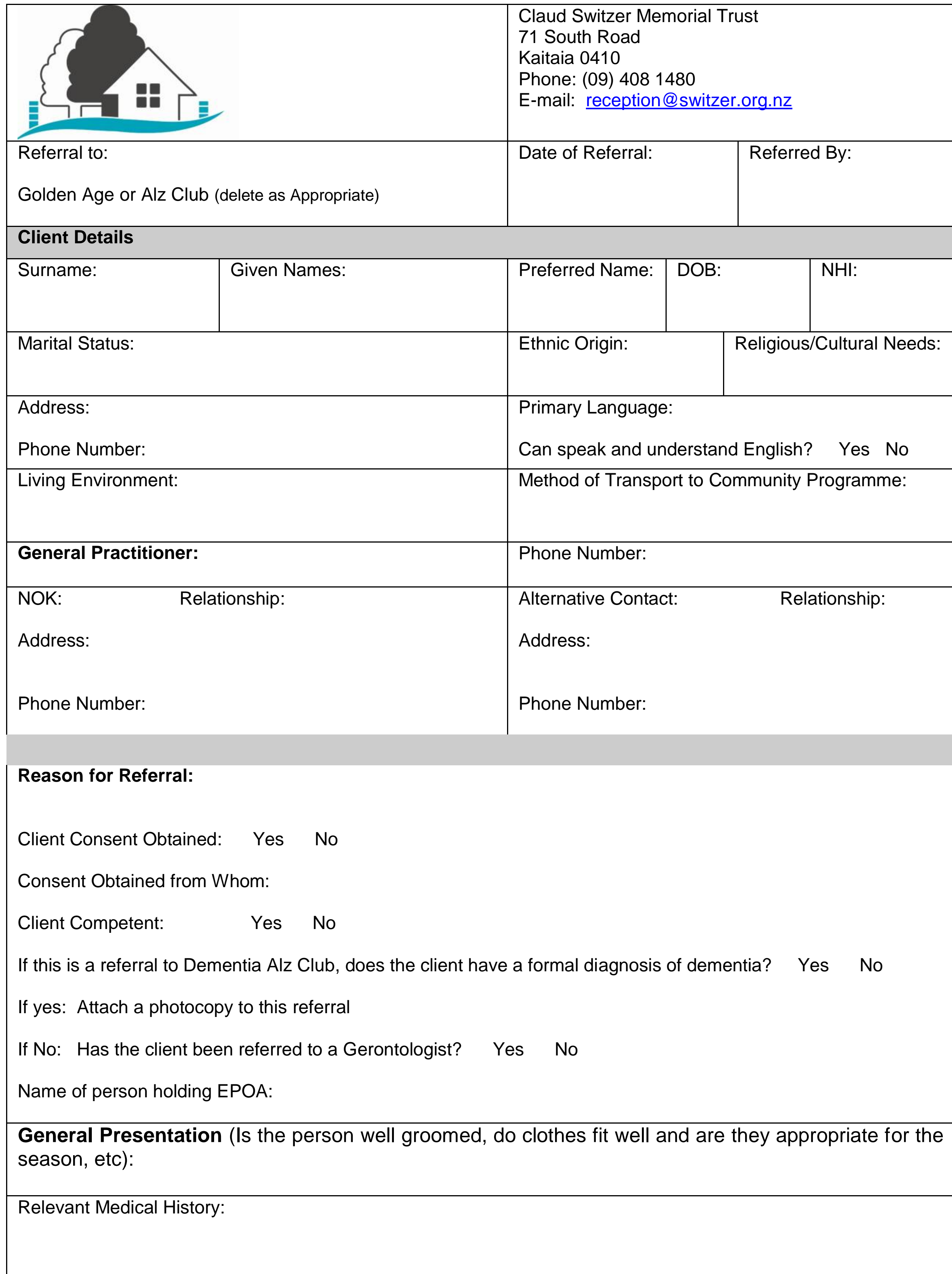
Community Program Referral

Please complete this form and forward it to the NASC team to process your referral.
Private Bag 9742 Whangarei, Email: nasc@northlanddhb.org.nz, Phone: 09 430 4131



Claud Switzer Memorial Trust
71 South Road
Kaitaia 0410
Phone: (09) 408 1480
E-mail: reception@switzer.org.nz

Referral to: Golden Age or Alz Club (delete as Appropriate)	Date of Referral:	Referred By:

Client Details

Surname:	Given Names:	Preferred Name:	DOB:	NHI:

Marital Status:	Ethnic Origin:	Religious/Cultural Needs:

Address: Phone Number:	Primary Language: Can speak and understand English? Yes No
Living Environment:	Method of Transport to Community Programme:
General Practitioner:	Phone Number:
NOK: Relationship: Address: Phone Number:	Alternative Contact: Relationship: Address: Phone Number:

Reason for Referral:

Client Consent Obtained: Yes No

Consent Obtained from Whom:

Client Competent: Yes No

If this is a referral to Dementia Alz Club, does the client have a formal diagnosis of dementia? Yes No

If yes: Attach a photocopy to this referral

If No: Has the client been referred to a Gerontologist? Yes No

Name of person holding EPOA:

General Presentation (Is the person well groomed, do clothes fit well and are they appropriate for the season, etc):

Relevant Medical History:

Current Medications/Treatments:

Allergies:

Social History / Community Involvement

Personal likes / Dislikes / Current Interests and Goals:

Cognitive/Behavioural Issues:

Does the client have a short-term memory / confusion / history of wandering / aggression / inappropriate behaviour? Are they agitated, anxious, hostile, tearful, depressed, angry, uncooperative. (circle as appropriate)

Do you know what triggers the behaviour?

What can be done to prevent it from occurring or make it better?

Additional Relevant Information

Activities of daily Living – Circle as Appropriate

Mobility: Independent / Supervision / Assistance X 1 / Assistance X 2

Mobility Aids: Walking stick / Frame / Wheelchair / Other Needs:

Personal Care / Washing and Dressing: Independent / Supervision / Assistance X 1 / Assistance X 2

Other:

Elimination: Continent / Toilet regularly / Incontinent of urine / Incontinent of urine and faeces / Catheterised

Aids:

Diet: Normal / Diabetic / Puree / Other:

Appetite: Good / Poor / Small meal / Medium meal / Large meal

Likes:

Dislikes:

Fluids preference:

Aids: High sided plate / Special cutlery / Feeder Cup

Eating: Independent / Supervision / Assistance / Feed

Dentures: Upper / Lower

Dietary Supplements:

Communication:

Language: Barrier / Difficulty:

Hearing: Good / Poor / Wears hearing aids R / L

Vision: Good / Poor / Wears glasses

Needs Assessor Name:	**Signature:**	**Date:**