AlfredHealth

UR

☐ Alfred ☐ Sandringham ☐ Caulfield

# REFERRAL TO CDAMS
## Cognitive Decline and Memory Service

| | | | |
|---|---|---|---|
| Family Name* | | Given Name* | |
| Date of Birth* | | Sex ☐ Female ☐ Male ☐ Other | |

*mandatory fields

Enquiries CDAMS T 9076 6010

**Send referral to** Caulfield Access Unit

F 03 9076 6773 E gcgmcaccess@alfred.org.au

Caulfield Hospital, 260 Kooyong Road, CAULFIELD VIC 3162

| **Patient Details** | | | | | |
|---|---|---|---|---|---|
| Address | | | | | |
| Telephone | | Email | | | |
| Interpreter | ☐ Yes ☐ No | Language | | | |
| Indigenous | ☐ Yes *list* | | ☐ No ☐ Not specified | | |
| ☐ Bulk Bill ☐ Private ☐ TAC ☐ WorkCover ☐ Pensioner ☐ DVA ☐ Other | | | | | |
| Medicare Number | | Reference | | Exp | |
| Cultural considerations | | | | | |
| Alternative Contact | Name | | | | |
| | Relationship | | Phone | | |

**CDAMS**

CDAMS will provide a comprehensive assessment and review of cognitive difficulties and possible dementia with the view to a diagnosis and management plan

- Indicate your expectations of a CDAMS assessment for your patient

| | | |
|---|---|---|
| Allergies ☐ Yes ☐ No | List | |

**Brief Medical History, noting any of the below & details** – *or attach detailed clinical notes*

| | | |
|---|---|---|
| Falls or unsteady gait | Lung disease | Incontinence |
| Problematic alcohol intake | Hypoxic brain insult | Other substance abuse |
| Cardiac arrest / surgery | Liver disease | Recent unexplained weight loss |
| Epilepsy | Head Injury | Significant vision or hearing impairment |
| Syphilis or HIV | Intellectual disability | Schizophrenia |
| Parkinson's disease | Other neurological deficit | Depression |
| Cancer | Anxiety | Kidney disease |



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| Family Name* | | Given Name* | |
|---|---|---|---|

**Vascular Risk Factors**

☐ Hypertension
☐ Diabetes
☐ History of smoking
☐ Ischaemic heart disease
☐ Valvular heart disease
☐ Hypercholesterolemia
☐ Stroke
☐ CCF
☐ AF or other arrhythmias
☐ Cardiac surgery

| If yes to the above, *describe* |
|---|
| Have there been any hospital admissions for the above? ☐ Yes ☐ No<br>If yes, *describe* |

| **Current Medications and Dosage**, *or attach list* | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

| **Investigations Results**– *attach copies* | | |
|---|---|---|
| FBE** | ESR | Glucose – Random** |
| Electrolytes & Creatinine** | Thyroid Function Test** | Liver function** |
| Calcium & Phosphate** | Vit B12** | Syphilis serology |
| **X-Ray Results** – *attach copies* | | |
| CT Brain Scan** | | |
| Chest X-Ray | **NB** If a plain (non-contrast) CT scan has not been done since the onset of dementia symptoms, please arrange one and forward report with the patient to the appointment. | |

**NB: ** if not done in the last 12 months, arrange for patient to complete**

| **Referrer Details** | | Date of Referral | | Provider No | |
|---|---|---|---|---|---|
| Name | | Address | | | |
| Telephone | | Email | | | |
| Fax | | Copies to | | | |

Thank you for the information provided. You will receive a full copy of results on completion of our assessment. If you have any queries do not hesitate to contact CDAMS on 9076 6010



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