Latrobe Regional Health

REFERRAL TO CDAMS

Cognitive Dementia and Memory Service

Surname		**First name**		
Date of Birth		**Gender**		
Address				
Telephone		**Email**		
Interpreter	☐Yes ☐No	Language		
Indigenous	☐No ☐Yes	Aboriginal ☐ Torres Strait Islander ☐ Both ☐		
Medicare Number		Reference	Exp	
Pension/ Health Care Number			Exp	
Cultural considerations				
Alternative Contact	Name			
	Relationship		Phone	

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 –

Attach brief medical history, noting any of the below & details

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

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Vascular Risk Factors					
	Hypertension		Cardiac surgery		History of smoking
	Ischaemic heart disease		Diabetes		Hypercholesterolemia
	Stroke		Valvular heart disease		
	AF or other arrhythmias		Congestive Cardiac Failure		

If yes to the above, describe-
Have there been any hospital admissions for the above? If yes, describe –

Current medications and dosage (or attach list)	

Referral tests attended –

☐ CT Brain

☐ MMSE or equivalent

☐ CTB

☐ Pathology

Calcium & Phosphate, Magnesium	Liver Function
Electrolytes / Creatinine	MSU (Urine)
ESR	Red Cell Folate
FBE	Thyroid TFT's
HbA1c	VDRL (Syphilis Serology)
Vitamin B12	Vitamin D

Referrer Details
Name
Clinic

Send referral to
CDAMS
Latrobe Regional Health
PO Box 424
Traralgon 3844

sacscdams@lrh.com.au
Fax 03 5173 8799