



Living with Memory Loss Referral Form for Service Providers

(Please complete the details of any clients you feel may be suitable for the Program and return it to the address below)

KEY CONTACT PERSON : *This person understands they will 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 (Bus) _____ Days/times _____
Restrictions on Contact:

PERSON WITH MEMORY LOSS/DEMENTIA

First Name _____ Surname _____
Street _____
Suburb/City _____ Postcode _____
Date of Birth _____ (or) Age ____yrs Male Female
Telephone (home) _____ (work) _____
(If diagnosed) -Type of dementia _____
Diagnosed by _____ Approx. date _____

REFERRED BY :

Name of Worker _____ Role _____
Organization _____ Phone _____
Street _____
Suburb/City _____ Postcode _____

I would like feedback concerning this referral Yes No

I have discussed this referral with the person being referred and they are expecting someone from AA NSW to contact them.

Signed _____ Date _____

Return to:

Alzheimer's Australia NSW
PO Box 6042
North Ryde NSW 1670

Ph 02 8875 4611
Fax 02 8875 4665