Dementia Rehabilitation Referral Form

Fill out this form to book with one of encara's allied health professionals.
Ensure all fields are completed prior to submitting to dementia@encara.com.au

encara
encompassing care

Participant Details

Full name

Street address | Suburb

City | Postcode

Phone | Email

Date of birth | Gender ☐ Male ☐ Female ☐ Other

Country of birth

Do you speak a language other than English | Interpreter required ☐ No ☐ Yes

Medicare Number | Reference Number | Expiry

Are you an Australian citizen ☐ No. ☐ Yes

Are you of Aboriginal and/or Torres Strait Islander origin ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

Do you live alone ☐ No ☐ Yes

Do you have a diagnosis of Dementia from a medically trained professional (e.g. GP or Specialist) ☐ No ☐ Yes

How did you hear about this program

Medical History and Diagnoses

I agree to have my personal information processed via email for the purpose of this referral ☐ No ☐ Yes

Primary Care Partner

Name

Phone | Email

Relationship

Do you live with the participant ☐ No ☐ Yes

Consent to provide clinical information to this contact ☐

Primary contact for communication and appointment coordination ☐

Referrer

Tick this box if the referrer is the Primary Care Partner ☐ Please leave this section blank if ticked

Name | Email

Phone

Consent to provide clinical information to this contact ☐

Primary contact for communication and appointment coordination ☐

Treating Medical Professional - General Practitioner or Specialist

Name

Phone | Email

Clinic Name & Address

Consent to provide clinical information to this contact ☐

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