Referral for Dementia Wellington Services™

Please complete all areas of this form and email to referrals@dementiawellington.org.nz or fax (04) 9380113

Dementia Wellington provides people with a dementia and their supporters tailored one-on-one advice, education, socialisation programme, support groups, and Total Mobility Scheme assessments.

Person with Dementia details	
Name:	Address: Suburb: Town: Postcode:
Email:	Telephone:
Date of birth:	Gender: M / F / Other
Ethnicity:	NHI:
GP:	Medical Practice name:
Medical Practice address:	Medical Practice phone:
Supporter/ Contact person details	
Name: Email:	Address:
Relationship:	Telephone:
Referral details	
Date of Referral:	Supporter aware of referral ☐ Person with Dementia aware of referral ☐
Who should be our first point of contact? Supporter ☐ Person with Dementia ☐	Diagnosed by: Date of Diagnosis:
Type of Dementia diagnosis: Other relevant diagnoses:	
Reason for referral (*E.g. Total Mobility Scheme assessment required, or carer stress)*	
Current professional or family supports involved	
Referrer details	
Name of Referrer:	Designation:
Organisation:	Phone number: