CarePartners of Connecticut

Dementia Care Consultation Referral Form

This form is to be used for CarePartners of Connecticut member referrals to the dementia care consultant. Once complete, please email form to cm_cpct@carepartnersct.com.

Member Name:________________________________ Member ID: ____________________________

Type of Dementia: _____________________________ CM Program: ___________________________

Member's Primary Contact: ______________________ Relationship to Member: _________________

Contact Primary Phone: ________________________ Alternate Phone: ________________________

PCP: ____ PCP Fax: _______________________________

Neurologist / Geriatric Psychiatrist: ____

Referring Care Manager: ________________________ Phone: _________________________________

HIPAA Permission Obtained from Member? ☐ YES ☐ NO ☐ N/A

Caregiver Assessment Score: ____________ ☐ N/A

Needs:

- ☐ Medical Issues (dx, medication, etc.)
- ☐ Increase Care / Support at Home
- ☐ Placement / Care Needs
- ☐ ADLs
- ☐ Symptom Management
- ☐ Caregiver Support
- ☐ Safety (driving, home alone, safe return, etc.)
- ☐ Support Groups / Education Programs
- ☐ Future Care Planning
- ☐ Early Stage Issues
- ☐ End-of-Life Issues

ADDITIONAL RELEVANT INFORMATION: