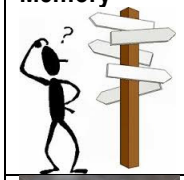
Markers of Decline addition information for referrals. Worker Name:	**Client Name:**	**Date:**
Memory 	**Referral to Dementia Nurse and/or AAV** [has the client shown signs of concern with their memory?] **Yes** **No** **Goal:**	
 **Homelessness**	**Referral to CAF's** [is the client at risk of homelessness?] **Yes** **No** **Goal**	
 **Medication**	**Referral for medication assistance.** [Does the client need support with their medication] **Yes** **No** **Goal**	
Travel training/Community Access 	**Referral to Occupational Therapist required** [if yes for what purpose, independence, to the shops, doctors, bus, train?] **Yes** **No** **Goal:**	
Meals on Wheels Review 	**Referral to Dietitian, Speech Therapist and Occupational Therapist** [if yes for what purpose, independence, meal preparation, shopping, nutritional assessment] **Yes** **No** **Goal:**	
Strength based programs 	**Referral to Physiotherapist/exercise physiologist** [Gentle exercises to music, falls and balance clinic, hydro therapy, make a move program] **Yes** **No** **Goal:**	

Continence referrals 	**Referral to Continence Nurse** [Are they having trouble with their bowels and/or bladder that causes them concern, embarrassment or pain] **Yes** **No** **Goal:**
 **Nutritional Health**	**Referral to Dietitian** Using the malnutrition screening tool **[**Has the client lost weight in the last 6 months without trying? Has the client been eating poorly because of a decreased appetite, eating less than ¾ of their meal? **Yes** **No** **Goal:**
Social Work, Counselling, 	**Social Worker** Is the client experiencing one or more stressful events in their life? [A referral for counselling, support, information and advocacy] **Yes** **No** **Goal:**
Swallowing 	**Speech Therapist** Does the client have difficulties swallowing food, drinking safely, suffer from a progressive neurological disease? **Yes** **No** **Goal:**
Foot Care 	**Podiatry [**Does the client have a foot problem that affects their ability to walk and move about?] **Yes** **No** **Goal:** Please complete the Foot Care screening tool and return it to your supervisor
Consent Given YES / NO Name Date	Get Consent to service form signed & leave them a copy