Aging & Adult Services
OF COASTAL WASHINGTON

DEMENTIA OUTREACH PROGRAM
REFERRAL FORM

*Email this form to **coastal.dementia@dshs.wa.gov***

Care Partner Name:	**Phone:**	
Email:		
Mailing Address: Number, Street, City, State, Zip Code		
Preferred Method of Contact:		
Okay to leave detailed message? YES ☐ / NO ☐ **If yes, how would you like staff to identify themselves?**		
Person living with dementia name and age:	**Relationship with Care Partner:**	
Type of Dementia (if known):	**Date of Diagnosis:**	**Lives w/care partner? YES ☐ / NO ☐**
Primary Concern(s):		

Interested In (check all that apply):

☐ Caregiver Education
☐ General Dementia Related Resources
☐ Dementia Legal Planning Resources
☐ STAR-C (clients must live together)
☐ SHARE for Dementia (MCI and early-stage care planning support)
☐ MoCA Screening
☐ Safety/Behavior Consultation
☐ Complex Care Needs Consultation
☐ Respite Resources
☐ Options Counseling
☐ Information on local support groups and/or memory cafes
☐ Other:

Referred by:	**Department/Agency:**	**Date:**
Phone:	**Email:**	

AASCW Staff Only

Enrollment in other AASCW Programs:
Has spoken with ADRC staff about options: YES ☐ / NO ☐
ADRC staff have entered this referral into CLC/GETCARE: YES ☐ / NO ☐