OLYMPIC AREA AGENCY ON AGING

DEMENTIA OUTREACH PROGRAM
REFERRAL FORM

Email this form to o3a.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:	**Relationship to 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 Training Classes □ Dementia Friends Training (Private / Professional) □ Options Counseling □ Dementia Legal Planning □ Advance Care Planning + Dementia □ STAR-C (CP/PLWD must live together) □ 1:1 Behavioral Expressions Consultation □ SHARE for Dementia (MCI and early-stage diagnosis care planning support)		
O3A Staff Only		
Referred by:	**Department/Agency:**	**Date:**
Phone:	**Email:**	
Enrollment in other O3A Programs:		
Has spoken with I&A staff about options: YES ☐ / NO ☐		