



ALZHEIMER'S
DISEASE
ASSOCIATION

REFERRAL FORM FOR FAMILY OF WISDOM

Please indicate preferred location (please tick)

- @ Bendemeer (Address : 72 Bendemeer Road #05-29 Luzerne Building)
 @Tiong Bahru (Address : 298 Tiong Bahru Road #10-05 Central Plaza)
 @Toa Payoh (Address : 7A Toa Payoh Lorong 8 #03-06 Agape Village)

Please fax this form to

FAX: 62916260 - For Bendemeer enquiries, or call Ms Eunice Tan at Tel: 62916268 / 90110263
or email : eunice@alz.org.sg

FAX: 62730996 - For Tiong Bahru & Toa Payoh enquiries, or call Ms Chong Ying Ying at Tel :
65936440 or email : yingying@alz.org.sg

PARTICULARS OF CLIENT

Surname _____ Name _____

NRIC No. _____ Sex *F / M* Date of Birth _____

Address _____

Postal code ()

Marital Status *Single / Married / Divorced / Separated / Widowed*

Race *Chinese / Malay / Indian / Others* _____ Dialect _____

Language Spoken *English / Mandarin / Malay / Tamil / Others* _____

Citizenship *Singaporean / PR / Foreigner*

PARTICULARS OF CONTACT PERSON / CAREGIVER

Name _____ Sex *F / M*

Relationship to client _____

Contact Numbers *Home* _____ *Office* _____

Mobile _____

Email Address _____

**NOTE: SECTION A, B & C to be completed by Medical Doctor / Nurse Clinician with
consent from family caregiver** Yes No

SECTION A. MEDICAL HISTORY

Type of dementia

- Alzheimer's Disease Vascular Others _____



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(Please tick : (i) Mild (ii) Mild to Moderate (iii) Moderate (iv) Moderate to Severe

Dementia Follow-up

Yes (Please provide details below) No

Doctor's Name _____ Designation _____

Hospital / Clinic _____ Next TCU date (if applicable) _____

Presenting Problem(s) – Cognitive and Behavioural (e.g. of behavioural problems – aggression, apathy, shouting, sleep disturbance, wandering, etc)

Other Medical Condition(s) & Summary of Investigations and Management

(Please attach memo if insufficient space)

Medications / Dosage / Frequency



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Drug Allergies No Yes (please specify: _____)

SECTION B. SCREENING

Does client currently have any active infectious disease?

No Yes (please specify: _____)

Are there any other precautions to be taken or conditions that would require closer monitoring?

No Yes (please specify: _____)

Results of Chest X-ray (if applicable) _____

SECTION C. CURRENT FUNCTIONAL STATUS Please tick

a) Mobility : (i) Ambulant Semi-ambulant

(ii) Use of walking aids: _____

b) Bladder : Continent Incontinent (Wears Pull-up Pants / Diapers)

c) Self-Care :

(i) Toileting : Independent Need Supervision Need Assistance

(ii) Dressing : Independent Need Supervision

(iii) Feeding : Independent Need Supervision

d) Visual impairment : Yes No

e) Hearing impairment : Yes No

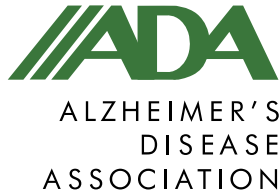
SECTION D. REFERRING DOCTOR

Name _____ Designation _____

Contact No. _____

Email _____

Hospital / Clinic / Ward _____



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SECTION E. SOCIAL HISTORY: (INCLUDING MAIN CAREGIVER)

SECTION F. ADDITIONAL DETAILS / INFORMATION

Latest AMT score : _____ (Date done : _____)

**SECTION G. PARTICULARS OF NURSE CLINICIAN / STAFF NURSE
COMPLETING THE FORM**

Name _____ Designation _____

Contact No. _____

Email _____

Hospital / Clinic / Ward _____



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SECTION H. CONSENTS

As the contact person/caregiver named on page 1 of this Referral Form I consent to:

- the doctor/hospital/clinic providing the personal data in this Referral Form to Alzheimer's Disease Association ('ADA') for the purpose of the doctor/hospital/clinic referring the client named on page 1 to ADA's Family of Wisdom programme and
- ADA collecting and using the personal data in this Referral form for the purposes of contacting me about admission of the client to that programme and
- ADA collecting and using any personal data obtained by observation of the client in any face-to-face meeting with ADA to consider their admission to the Family of Wisdom programme

Signature of contact person/caregiver named on page 1

Date