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 _____

ALZHEIMER'S DISEASE ASSOCIATION

REFERRAL FORM FOR FAMILY OF WISDOM

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 _____

ALZHEIMER'S DISEASE ASSOCIATION

REFERRAL FORM FOR FAMILY OF WISDOM

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 ('ÁDA') 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