ALZHEIMER'S DISEASE ASSOCIATION

CAREGIVER SUPPORT SERVICES REFERRAL FORM

SOURCE OF REFERRAL

Date	Name / Designation	Organisation / Department

Contact Number	Fax Number	Email Address

Service(s) Required: ❑ Casework & Counselling ❑ Eldersit Respite Care Service ❑ Person-Centered Home-Based Intervention

CONFIRMATION OF CONSENT

I confirm that the main caregiver named in this Caregiver Support Services Referral Form has consented to us providing their personal data and person with dementia's latest hospital discharge summary/medical memo to Alzheimer's Disease Association for the purpose of this referral.

_______________________________ (Signatory of referring staff)

_______________________________ (Date)

PARTICULARS OF PERSON WITH DEMENTIA

Name (As per NRIC)	NRIC No.	Date of Birth / Age

Address (As per NRIC)	Gender	Contact Number

Nationality
❑ Singaporean
❑ Singapore PR
❑ Others ( )

Marital Status
❑ Single ❑ Married
❑ Divorced ❑ Widowed
❑ Separated

Race
❑ Chinese ❑ Indian
❑ Malay ❑ Eurasian
❑ Others ( )

Religion
❑ Buddhism ❑ Christianity
❑ Islam ❑ Hinduism
❑ Others ( )

Language(s) / Dialect(s) Spoken
❑ English ❑ Mandarin ❑ Malay ❑ Tamil
❑ Teochew ❑ Hokkien ❑ Cantonese
❑ Others (Please state:)

MEDICAL INFORMATION OF PERSON WITH DEMENTIA

(For Doctor's Completion)

Diagnosis and Type of Dementia

❑ Alzheimer's Disease ❑ Multi-infarct / Vascular ❑ Others ( )

❑ With medical follow-up (Hospital/Clinic:) ❑ Without medical follow-up

Name & Signature of Doctor: _______________________________ MCR no.: ____________________

Hospital / Clinic / Designation: _______________________________ Date: ______________________

Cognitive & Behavioral Symptoms (Please tick if present)

Activity Disturbances:	❑ Wandering	❑ Purposeless Activity	❑ Inappropriate activity
Aggressiveness:	❑ Agitation	❑ Verbal Outburst	❑ Physical threats / Violence
Affective Disturbances:	❑ Tearfulness	❑ Depressed Mood	❑ Anxieties & Phobia
Psychological Symptoms:	❑ Hallucinations	❑ Paranoid / Delusions	❑ Day / Night Disturbances

CAREGIVER SUPPORT CENTRE | 70 Bendemeer Road #03-02A Luzerne Building Singapore 339940
DEMENTIA HELPLINE: 6377 0700 FAX NUMBER: 6293 6631 EMAIL: infocsc@alz.org.sg

Updated 07 Aug 2018

PARTICULARS OF MAIN CAREGIVER

Name (As per NRIC)	NRIC No.	Date of Birth / Age

Address (As per NRIC)	Gender

Contact Number	Email Address	Relationship to Person with Dementia

Nationality	Marital Status	Race
❑ Singaporean ❑ Singapore PR ❑ Others ( )	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated	❑ Chinese ❑ Indian ❑ Malay ❑ Eurasian ❑ Others ( )

Religion	Language(s) / Dialect(s) Spoken
❑ Buddhism ❑ Christianity ❑ Islam ❑ Hinduism ❑ Others ( )	❑ English ❑ Mandarin ❑ Malay ❑ Tamil ❑ Teochew ❑ Hokkien ❑ Cantonese ❑ Others (Please state:)

SOCIAL & FINANCIAL INFORMATION

Family Background *(Please attach a Social Report if it is available)*

ILTC Means Test Completed ❑ Yes ❑ No ❑ Not Applying ❑ NA

(Upon means test completion, please attach together all relevant documents.)

Subsidy eligibility ❑ Yes, pls specify: ____________ % ❑ No ❑ NA / Not Administered

PRESENTING ISSUES & ADDITIONAL INFORMATION / REMARKS

(Please attach a Social Report if it is available)

REFERRAL OUTCOME (For Official Use)

❑ Accepted ❑ Rejected with reason(s) as follows:

Date	Name / Designation	Contact Number