REFERRAL FORM FOR FAMILY OF WISDOM

Please Indicate Preferred Location (*please tick* ☑)

Preferred location (✓)	No. of Clients Per Group	Mild Dementia	Moderate Dementia	Moderate to Severe Dementia	Severe Dementia
		12	8	4	1
	FOW @ Bendemeer	X	X	X	X
	FOW @ Tiong Bahru	X	X		
	FOW @ Toa Payoh	X			

Fax this form to :

☐ FOW @ Bendemeer (Add : 72 Bendemeer Road #05-29 Luzerne Building) **FAX: 62916260**

I/C : Ms Eunice Tan at Tel: 62916268 / 90110263 or email : eunice@alz.org.sg

☐ FOW @Tiong Bahru (Add : 298 Tiong Bahru Road #10-05 Central Plaza) **FAX: 62730996**

I/C : Ms Pamela Soh at Tel : 65936440 or email : pamela@alz.org.sg OR Ms Chong Ying Ying at Tel : 69044095 or email : yingying@alz.org.sg

☐ FOW @Toa Payoh (Add : 7A Toa Payoh Lorong 8 #01-01 Agape Village) **FAX: 69044096**

I/C : Ms Chong Ying Ying at Tel : 69044095 or email : yingying@alz.org.sg

PARTICULARS OF CLIENT

Name ____

NRIC No. ___________________ **Sex** *F / M* **Date of Birth** _____________________

Address ____ **Postal code (** **)**

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

Race *Chinese / Malay / Indian / Others* ____________________

Preferred Spoken Language *English / Mandarin / Hokkien / Cantonese / Teochew / Malay / Tamil / Others* ___________________________

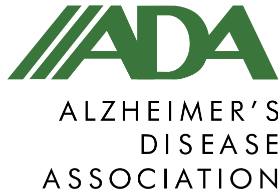
Citizenship *Singaporean / PR / Foreigner*

PARTICULARS OF CONTACT PERSON / CAREGIVER

Name ________________________ **Sex** *F / M* **Relationship to client** _______________________

Contact Numbers ***Home*** ________________________ ***Office*** _______________________

Mobile ________________________ ***Email*** ____



REFERRAL FORM FOR FAMILY OF WISDOM

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 (Please tick ☑):

☐ Alzheimer's Disease ☐ Vascular ☐ Mixed ☐ ________________

Stage of Dementia (Please tick ☑):

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ 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)*

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

(*Please attach memo if insufficient space*)

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ALZHEIMER'S
DISEASE
ASSOCIATION

REFERRAL FORM FOR FAMILY OF WISDOM

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 :

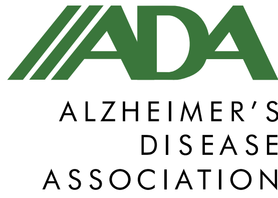
(i) Toileting : ☐ Independent ☐ Need Supervision ☐ Need Assistance

(ii) Dressing : ☐ Independent ☐ Need Supervision

(iii) Feeding : ☐ Independent ☐ Need Supervision

d) Visual impairment : ☐ Yes ☐ No

e) Hearing impairment : ☐ Yes ☐ No



REFERRAL FORM FOR FAMILY OF WISDOM

SECTION D. REFERRING DOCTOR

Name ________________________________ Designation ________________________

Contact No. ____

Email ____

Hospital / Clinic / Ward ____

SECTION E. SOCIAL HISTORY: (INCLUDING MAIN CAREGIVER)

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____

SECTION F. ADDITIONAL DETAILS / INFORMATION

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____
____
____
____
____
____

Latest AMT / MMSE score : _____________ (Date done : ______________________________)

REFERRAL FORM FOR FAMILY OF WISDOM

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

Name ______________________________ Designation ______________________________

Contact No. ____

Email ____

Hospital / Clinic / Ward ____

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