CAREGIVER SUPPORT SERVICES REFERRAL FORM

ALZHEIMER'S DISEASE ASSOCIATION

SOURCE OF REFERRAL

Date: _____

Name / Designation: _____ **Organisation / Department:** _____

Contact No.: _____ **Fax No.:** _____ **Email Address:** _____

Service(s) Required:

- ☐ Casework & Counselling
- ☐ Eldersit Respite Care Service
- ☐ Person-Centred 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: _____ **Gender:** _____ **Contact No.:** _____

Address (As per NRIC): _____

Citizenship:

- ☐ Singaporean
- ☐ Singapore PR
- ☐ Others ( )

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Race:

- ☐ Chinese
- ☐ Malay
- ☐ Indian
- ☐ Eurasian
- ☐ Others ( )

Religion:

- ☐ Buddhism
- ☐ Christianity
- ☐ Islam
- ☐ Hinduism
- ☐ Others ( )

Language(s) / Dialect(s) Spoken:

- ☐ English
- ☐ Mandarin
- ☐ Malay
- ☐ Tamil
- ☐ Teochew
- ☐ Hokkien
- ☐ Cantonese
- ☐ Others ( )

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)

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

CAREGIVER SUPPORT SERVICES REFERRAL FORM

ALZHEIMER'S DISEASE ASSOCIATION

PARTICULARS OF MAIN CAREGIVER

Name (As per NRIC): _____ **NRIC No.:** _____

Date of Birth / Age: _____ **Gender:** _____ **Contact No.:** _____

Address (As per NRIC): _____

Email Address: _____ **Relationship to Person with Dementia:** _____

Citizenship:
- ☐ Singaporean
- ☐ Singapore PR
- ☐ Others ( )

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Race:
- ☐ Chinese
- ☐ Malay
- ☐ Indian
- ☐ Eurasian
- ☐ Others ( )

Religion:
- ☐ Buddhism
- ☐ Christianity
- ☐ Islam
- ☐ Hinduism
- ☐ Others ( )

Language(s) / Dialect(s) Spoken:
- ☐ English
- ☐ Mandarin
- ☐ Malay
- ☐ Tamil
- ☐ Teochew
- ☐ Hokkien
- ☐ Cantonese
- ☐ Others ( )

SOCIAL & FINANCIAL INFORMATION

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

CAREGIVER SUPPORT CENTRE • 20 Bendemeer Road #01-02 BS Bendemeer Centre, Singapore 339914
DEMENTIA HELPLINE: **6377 0700** | FAX NUMBER: **6293 6631** | EMAIL: **infocsc@alz.org.sg**

CAREGIVER SUPPORT SERVICES REFERRAL FORM

ALZHEIMER'S DISEASE ASSOCIATION

ILTC Means Test Completed:

☐ Yes ☐ No ☐ Not Applying ☐ NA

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

Subsidy eligibility:

☐ Yes (_____ %) ☐ 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 No.:** _____

CAREGIVER SUPPORT CENTRE • 20 Bendemeer Road #01-02 BS Bendemeer Centre, Singapore 339914
DEMENTIA HELPLINE: **6377 0700** | FAX NUMBER: **6293 6631** | EMAIL: **infocsc@alz.org.sg**