FAMILY OF WISDOM REFERRAL FORM

ALZHEIMER'S DISEASE ASSOCIATION

Type of Sessions Available	FOW (Bendemeer)	FOW (Tiong Bahru)
Mild Dementia	●	●
Moderate Dementia	●	●
Moderate to Severe Dementia	●	×
Severe Dementia	●	×

Please tick (✓) preferred location:

☐ **FOW (Bendemeer)**
20 Bendemeer Road
#01-02 BS Bendemeer Centre

☐ **FOW (Tiong Bahru)**
298 Tiong Bahru Road
#10-05 Central Plaza

Please fax this referral form to your preferred location:

FOW (Bendemeer)
FAX: **6293 6631**
I/C: Ms Eunice Tan
6389 5385 / 9011 0263
eunice@alz.org.sg

FOW (Tiong Bahru)
FAX: **6273 0996**
I/C: Ms Pamela Soh
6593 6440
pamela@alz.org.sg
Ms Chong Ying Ying
6904 4095
yingying@alz.org.sg

PARTICULARS OF CLIENT

Name: _____

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

Address: _____ **Postal Code:** _____

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

Citizenship:
☐ Singaporean
☐ Singapore PR
☐ Others ( )

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

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

PARTICULARS OF CONTACT PERSON / CAREGIVER

Name: _____

Gender: _____ **Relationship to client:** _____

Contact No.: Home _____ Office _____ Mobile _____

Email Address: _____

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FAMILY OF WISDOM REFERRAL FORM

ALZHEIMER'S DISEASE ASSOCIATION

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
- ☐ Mixed
- ☐ Others ( )

Stage of Dementia:

- ☐ Mild
- ☐ Mild to Moderate
- ☐ Moderate
- ☐ Moderate to Severe
- ☐ Severe

Dementia Follow-up:

☐ Yes (Please provide details below)

Doctor's Name: _____

Designation: _____

Hospital / Clinic: _____

Next TCU Date (if applicable): _____

☐ No

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:

Drug Allergies:

- ☐ No
- ☐ Yes (Please specify:)

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ALZHEIMER'S DISEASE ASSOCIATION

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

Mobility:

☐ Ambulant
☐ Semi-ambulant
☐ Use of walking aids: _____

Bladder:

☐ Continent
☐ Incontinent (Wears Pull-up Pants / Diapers)

Self-care:

1. Toileting:
   - ☐ Independent
   - ☐ Need Supervision
   - ☐ Need Assistance
2. Dressing:
   - ☐ Independent
   - ☐ Need Supervision
3. Feeding:
   - ☐ Independent
   - ☐ Need Supervision

Visual impairment:

☐ Yes
☐ No

Hearing impairment:

☐ Yes
☐ No

SECTION D: REFERRING DOCTOR

Name: _____ **Designation:** _____

Contact No.: _____ **Email:** _____

Hospital / Clinic / Ward: _____

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FAMILY OF WISDOM REFERRAL FORM

ALZHEIMER'S DISEASE ASSOCIATION

SECTION E: SOCIAL HISTORY (INCLUDING MAIN CAREGIVER)

SECTION F: ADDITIONAL DETAILS / INFORMATION

Latest AMT / MMSE score: _____ (Date done: _____)

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 ('ADA') for the purpose of the doctor / hospital / clinic referring the client named on page 1 to ADA's Family of Wisdom programme
- 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
- 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)

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