



Alzheimer's and Dementia Care Program
200 UCLA Medical Plaza, Suite 365A
Los Angeles, CA 90095
dementia@mednet.ucla.edu
(310)319-3222

We are looking forward to seeing you and your loved one for an annual visit with their Dementia Care Manager with our Alzheimer's and Dementia Care Program.

Please find attached the following forms to be completed by the caregiver/patient.

- Forms to be filled out by the patient or caregiver, regarding the **patient** over the course of the last year:
 - Form C1 - Follow up Questionnaire
 - Form C3 - Evaluation for Problematic Behaviors (NPI-Q)

Please make sure to bring the completed forms to your visit. If you are unable to fill them out beforehand, we ask you arrive at your appointment 30 minutes earlier, to do so.

It is very important to have at least one family member/caregiver at the appointment.

If you have any questions about your appointment or the forms, please feel free to contact us at dementia@mednet.ucla.edu or (310) 319-3222.

Sincerely,

Handwritten signature of Zaldy S. Tan in black ink.

Zaldy S. Tan, M.D., M.P.H.
Medical Director
UCLA Alzheimer's and Dementia Care Program

Handwritten signature of David B. Reuben in black ink.

David B. Reuben, M.D.
Chief, Division of Geriatrics

8. Daily Activities

Please check the most appropriate box for each task

	No Help Needed	Help Needed	Who Helps?
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
Getting from bed to chair	<input type="checkbox"/>	<input type="checkbox"/>	
Getting to the toilet	<input type="checkbox"/>	<input type="checkbox"/>	
Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing or showering	<input type="checkbox"/>	<input type="checkbox"/>	
Walking across the room (includes using cane or walker)	<input type="checkbox"/>	<input type="checkbox"/>	
Using the telephone	<input type="checkbox"/>	<input type="checkbox"/>	
Taking your medicines	<input type="checkbox"/>	<input type="checkbox"/>	
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	
Managing money (like keeping track of expenses or paying bills)	<input type="checkbox"/>	<input type="checkbox"/>	
Moderately strenuous housework such as doing the laundry	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping for personal items like toiletries, medicines or groceries	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing a flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	
Getting to places beyond walking distance (e.g. by bus, taxi, or car)	<input type="checkbox"/>	<input type="checkbox"/>	

Daily Activities Continued

A. Do you use a walking aid such as a cane or a walker? Yes No

If yes, which ones? Cane Walker Wheelchair

B. Are you afraid of falling? Yes No

C. Have you had a fall in the past year? Yes No

9. RESOURCES AND SERVICES *In the past year:*

A. Any changes in living situation?

1. Yes No (Skip to question B)

If yes, please provide new address:

_____	_____	
Street	Apartment	
_____	_____	_____
City	State	Zip

2. With whom do you live? (Check all that apply)

- Alone
- Spouse or Partner
- Child
- Other family member (specify): _____
- Others, not family (specify): _____

3. Which of the following best describes your residence:

- Single-family house
- Condo
- Apartment
- Board & Care/Assisted living
- Nursing Home
- Other (specify): _____

B. Do you pay someone to provide health related care or help in your home?

1. Yes No (Skip to question C)

2. How many hours per day and days per week, is the paid helper available to you?

_____ Hours _____ Days per week (e.g. 3 hours, 5 days a week)

3. Is this an increase from last year? Yes No

4. Is this sufficient to meet your needs? Yes No

C. Do you get help from family members or friends in your home?

1. Yes No (Skip to question D)
2. How many hours per day and days per week, is the helper available to you?
 _____ Hours _____ Days per week (e.g. 3 hours, 5 days per week)
3. Is this an increase from last year? Yes No
4. Is this sufficient to meet your needs? Yes No
5. Please name family/friend that provides help: _____
6. If this family/friend were to get sick or hospitalized, who would provide help?

D. Who would you call if you were sick and needed help? (Enter all that apply)

Name	Phone Number	Relationship	Permission to speak to this person on your behalf?
1.		<input type="checkbox"/> Spouse <input type="checkbox"/> Neighbor <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Spouse <input type="checkbox"/> Neighbor <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Spouse <input type="checkbox"/> Neighbor <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

E. Outside of UCLA, is anybody (agency or person) helping you get the information or services you need? Yes No

If yes, how often?

- Monthly Every 3 months Every 6 months As needed Not at all

Which organizations?

F. Please check the appropriate box for each service (Caregiver, Day-to-Day, Social) to indicate the services you are currently receiving and what services *if any*, you would be interested in receiving.

Day-To-Day Services

Currently receiving Interested in receiving

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Transportation (e.g. subsidies, public, door-to-door services) |
| <input type="checkbox"/> | <input type="checkbox"/> | Nutrition Services (meal delivery, shopping, meal preparation) |
| <input type="checkbox"/> | <input type="checkbox"/> | Adult Day Care services |
| <input type="checkbox"/> | <input type="checkbox"/> | Access to communication (e.g. TTY, instruments for the hearing impaired) |
| <input type="checkbox"/> | <input type="checkbox"/> | Home Health Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Home safety modification (e.g. bathroom bars, commodes, etc.) |

Social Services

Currently receiving Interested in receiving

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Social Work services |
| <input type="checkbox"/> | <input type="checkbox"/> | Housing services (e.g. subsidized housing, discrimination, landlord disputes, homelessness) |
| <input type="checkbox"/> | <input type="checkbox"/> | Care coordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Legal advocacy |

Financial Services

Currently receiving Interested in receiving

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Savings |
| <input type="checkbox"/> | <input type="checkbox"/> | Social Security Disability Insurance (SSDI) |
| <input type="checkbox"/> | <input type="checkbox"/> | Social Security Retirement benefits |
| <input type="checkbox"/> | <input type="checkbox"/> | Medicare |
| <input type="checkbox"/> | <input type="checkbox"/> | Retirement Income/Pension |
| <input type="checkbox"/> | <input type="checkbox"/> | MediCal |
| <input type="checkbox"/> | <input type="checkbox"/> | In-Home Supportive Services (IHSS; MediCal only program) |
| <input type="checkbox"/> | <input type="checkbox"/> | Long term care insurance |
| <input type="checkbox"/> | <input type="checkbox"/> | Supplemental Security Income |
| <input type="checkbox"/> | <input type="checkbox"/> | Other income (e.g. trust, annuity) |
| <input type="checkbox"/> | <input type="checkbox"/> | VA Benefits |

(Patient Label)

G. Property: Do you currently own or rent any property or business? Yes No

H. Financial Concerns: Do you have any concerns regarding patient finances (e.g. paying for caregiver)? Check all that apply.

- Yes, current concerns
- No concerns now, but maybe in the future
- No concerns at all

I. Legal Concerns: Do you have any legal concerns (e.g. conservatorship, advance directives)? Check all that apply.

- Yes, current concerns
- Yes, future concerns
- No concerns

FOR CAREGIVERS: Caregiver Services

Currently receiving Interested in receiving

- Respite or break for caregiver
- Caregiver Support Group
- Consultation or help in planning for board and care or assisted living placement
- Hospice Care
- Private In-Home care (privately paid caregiver)
- In-Home Supportive Services (MediCal only program)

10. Please list specific health concerns that you would like the care manager to know about before your visit.

Please be sure to include any information not already reported in this form.

- 1)
- 2)
- 3)

THANK YOU FOR COMPLETING THIS FORM
Please visit our website <http://dementia.uclahealth.org/>