



Alzheimer's and Dementia Care Program
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Welcome to the UCLA Alzheimer's and Dementia Care Program. We are looking forward to working with you in providing **comprehensive and coordinated dementia care management**. This letter introduces you to the program and tells you what to expect. The program will partner with your physician in addressing your dementia-related medical and psychosocial issues. Your entry into the program begins with an evaluation of your needs and resources, completed with information from the patient, family members and other caregivers. Based on the initial assessments, a **Dementia Care Manager** (with input from a physician dementia specialist) will work with you to create a **personal care plan**, which will be sent to your physician for approval or modification.

EVALUATION

Important things to bring to your evaluation:

- Please complete the enclosed questionnaires and *bring the completed forms to your first appointment*. The information you provide is an important part of the evaluation process. Here is a breakdown of the questionnaires, which are to be completed by the patient or caregiver, regarding the patient:
 - Form B1 - Pre-Visit Questionnaire
 - Form B2 – Evaluation for problematic behaviors

Please bring any old medical records and test results from previous evaluations you feel we should know about to your first clinic appointment.

- It is important that a family member and/or a friend/caregiver who can provide information on your current problems and your past history accompany you to the visit.
- **Please plan to arrive at least 20 minutes prior to your appointment**

Evaluation process:

You will be in the clinic approximately **90 minutes** on your first visit. Your Dementia Care Manager will evaluate you and work with you in producing a Dementia Care Plan.

The evaluation includes a review of your medical history, tests of memory and language, and standardized questionnaires meant to get to know you and your needs better. Additional members of our program team may assist in interviewing you and the family member or friend who comes with you.

RESEARCH and TEACHING

UCLA is a teaching hospital and as such, you may be seen by your care manager in conjunction with a trainee or student. Please inform us if you do not want to have a student or trainee present at your visit. As a research hospital, we partner with the Easton Center and other researchers to conduct clinical trials to investigate experimental drug treatments and other research designed to help investigators better characterize and understand memory loss and dementia. If you are interested in participating in experimental drug trials or in other research, your Dementia Care Manager will discuss these options with you. Please note: information from your assessment will not be available to researchers unless you give written permission.

THANK YOU

We are delighted that you have chosen to join the UCLA Alzheimer's and Dementia Care Program. Please let us know if you have suggestions about how our services may be improved.



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



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

Unless otherwise indicated, please fill out the rest of this form from the patient's perspective.

9. Who has been your primary care doctor? Provide information below.

UCLA Geriatrics Westwood UCLA Geriatrics Santa Monica Other

Name: _____

Address: _____
Street Suite

City State Zip

Phone number: (____) ____ - _____ Fax number: (____) ____ - _____

10. SPECIALIST(S)

Do you currently have a specialist (e.g. neurology or psychology) that manages your Alzheimer's disease, dementia or mood disorder?

Yes No

If Yes,

Name: _____

Address: _____
Street Suite

City State Zip

Phone number: (____) ____ - _____ Fax number: (____) ____ - _____

11. ALLERGIES

Do you have any drug allergies? Yes No

If yes, please list name of drug and indicate reaction.

Name of Drug	Describe Reaction
1.	
2.	

12. MEDICATIONS

Have you ever been prescribed dementia medications? Yes No

If yes, please check all appropriate boxes

- Aricept (Donepezil) Namenda (Memantine) Axona
 Exelon (Rivastigmine) Razadyne (Galantamine)

List all medications, including all prescription, non-prescription, and natural products

Current Medication	What strength?	How do you use it? (How many? How many times a day?)
Example: Tylenol	500mg	1 pill 3x a day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

13. HOSPITALIZATIONS/SKILLED NURSING VISITS

Please list all hospitalizations including neuropsychiatric hospitalizations outside UCLA for the last 2 years.

Which Hospital/Skilled Nursing Facility?	Reason for Hospitalization/SNF Visit	Year

14. PATIENT SOCIAL HISTORY

A. With whom do you live?

(Please check all that apply)

- Alone
- Spouse or Partner
- Child
- Other family member (specify):

Others, not family (specify):

B. Which of the following best describes your residence?

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

1. Do you: Own Rent
2. How long have you lived there?

3. What floor do you live on? _____
4. Do you take the stairs? Yes No
If yes, how many steps? _____

C. You are presently:

- Single/Never married
- Married
- Divorced/Separated
- Widowed
- Living with significant other

1. Do you consider yourself to be:
 - Heterosexual or straight
 - Gay or lesbian
 - Bisexual
 - Prefer not to answer

D. How many children do you have?

Number: _____

Are you in regular contact with at least one of your children?

- Yes No

E. How much school did you complete?

- Less than 8th grade
- Some high school
- High school graduate
- Some college
- College graduate
- Graduate school

F. Please specify your ethnicity

- Hispanic or Latino
- Not Hispanic or Latino

G. Please specify your race

- American Indian or Alaska Native
- Asian
- Black or African American
- Pacific Islander
- White

H. List your principal occupation and any other significant past occupations

1. _____
2. _____
3. _____

**I. Who would you (the patient) 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

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

Yes No

1. If yes, 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 per week)

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

K. Do you get help from family members or friends in your home? Yes No

1. If yes, 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)

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

3. Please name family/friend who provides help: _____

4. If this family/friend were to get sick or hospitalized, who would provide help?

L. How often do you (the patient) drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

Daily A few days a week (specify number of days: _____)
 Less than once a week Never

1. How much do you drink at a time? (One drink = 12 oz of beer or 8-9 oz of malt liquor or 5 oz of table wine or 1.5 oz of hard alcohol)

1 drink 2 drinks 3 drinks 4 drinks 5+ (how many? _____)

2. Has anyone ever been concerned about your drinking? Yes No

M. Do you currently smoke? Yes No

N. Have you ever used or abused drugs? Yes No Unknown

O. Are you sexually active? Yes No Unknown

P. Do you currently participate in any regular activity to improve or maintain your physical fitness? (either on your own or in a formal class)

Yes No

If yes, please list all activities:

Days per week	Amount of time per day
<input type="checkbox"/> 1 <input type="checkbox"/> 5	_____ Minutes
<input type="checkbox"/> 2 <input type="checkbox"/> 6	_____ Hours
<input type="checkbox"/> 3 <input type="checkbox"/> 7	
<input type="checkbox"/> 4	

15. PATIENT FAMILY HISTORY

A. Have any members of your family had memory problems? Yes No

16. DRIVING

A. Do you have a valid Driver's License? Yes No

B. If yes, are you currently driving? Yes No

17. SAFETY

A. Are there any firearms in your home? Yes No

B. Do you have a history of wandering or getting lost while outside of the home? Yes No

18. PLANNING FOR FUTURE HEALTH CARE

Who should speak for you if you're unable to make health decisions?

Name: _____

Relationship: _____

Phone number: (_____) _____

Do you have a living will/advance directive/out of hospital DNR form/POLST (Physicians Orders for Life Sustaining Treatment)? Yes No Unsure

If yes, please bring a copy

19. 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

20. During the LAST 3 MONTHS have you had any of the following symptoms or problems?

(Please check all that apply)

A. General Problems

- Weight loss Weight gain
- Change of appetite Wandering

B. Ear, Nose, Mouth, Throat

- Trouble hearing
- Swallowing problems
- Special diet? _____
- Consistency? _____
- Teeth problems

C. Eyes

- Trouble seeing

D. Skin Problems

- Rash Ulcers

E. Lung Problems

- Cough when eating
- Difficulty breathing or shortness of breath

F. Heart problems

- Chest pain or tightness
- Lightheadedness
- Irregular heart beat
- Rapid heart beat

G. Brain and Nervous System Problems

- Frequent headaches
- Frequent dizzy spells
- Passing out or fainting
- Paralysis, leg or arm weakness
- Numbness or loss of feeling
- Tremor or shaking

H. Digestive Problems

- Abdominal pain
- Constipation
- Frequent indigestion or heartburn
- Frequent nausea or vomiting
- Persistent constipation
- Frequent diarrhea
- Bleeding from rectum
- Black bowel movement

I. Kidney & Urinary Tract Problems

- Frequent urination
- Painful urination
- Difficulty starting or stopping urination
- Frequent urine infection
- Urination at night
- If yes, how many times a night: ____
- Loss of urine or getting wet

21. Access to Resources & Services

Please check the appropriate box for each service to indicate the service 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 |

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

B. 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

C. 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 Interested in
receiving receiving

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Respite or break for caregiver |
| <input type="checkbox"/> | <input type="checkbox"/> | Caregiver Support Group |
| <input type="checkbox"/> | <input type="checkbox"/> | Consultation or help in planning for board and care or assisted living placement |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospice Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Private In-Home care (privately paid caregiver) |
| <input type="checkbox"/> | <input type="checkbox"/> | In-Home Supportive Services (MediCal only program) |

22. 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/>