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
Alzheimer’s and Dementia Care Program
PRE-VISIT PATIENT QUESTIONNAIRE

**We highly recommend completing the following form with a caregiver or family member**

Thank you for investing the time to complete this form. The information you provide will allow your care manager to perform the most complete evaluation possible during your appointment.

**PATIENT INFORMATION**

1. Date form completed: ___ / ___ / ______
   
   MM    DD    YYYY

2. Name of patient: __________________________________________
   
   Last
   
   First

3. Mailing Address:
   
   Street
   
   Apartment
   
   City
   
   State
   
   Zip

4. Phone: (____) _____ - _________

5. Date of birth: ___ / ___ / ______
   
   MM    DD    YYYY

6. Sex:  [ ] Male   [ ] Female

7. What is the patient’s primary language spoken? _______________________________
   
   Secondary? ______________________________

8. Who filled out this form?
   
   [ ] Patient (Skip to question 9)   [ ] Other (please provide information below)

   Name: ________________________________  Phone number: (____) _____ - _________

   Mailing Address:
   
   Street
   
   Apartment
   
   City
   
   State
   
   Zip

   Email address: ________________________________

   If other person completed this form, what is the relationship of the person to the patient?
   
   [ ] Spouse   [ ] Child   [ ] Friend   [ ] Other (specify): ________________________________

   What is the best time during business hours to contact you? ________________________________

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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.

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Describe Reaction</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Current Medication</th>
<th>What strength?</th>
<th>How do you use it? (How many? How many times a day?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Tylenol</td>
<td>500mg</td>
<td>1 pill 3x a day</td>
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<td>1.</td>
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<td>2.</td>
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<td>4.</td>
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<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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<td>9.</td>
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<td>11.</td>
<td></td>
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<tr>
<td>12.</td>
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</tbody>
</table>
13. HOSPITALIZATIONS/SKILLED NURSING VISITS
Please list all hospitalizations including neuropsychiatric hospitalizations *outside* UCLA for the last 2 years.

<table>
<thead>
<tr>
<th>Which Hospital/Skilled Nursing Facility?</th>
<th>Reason for Hospitalization/SNF Visit</th>
<th>Year</th>
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</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Relationship</th>
<th>Permission to speak to this person on your behalf?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other ___________</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other ___________</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other ___________</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

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:
___________________________
___________________________
___________________________
___________________________
___________________________

<table>
<thead>
<tr>
<th>Days per week</th>
<th>Amount of time per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1 ☐ 5</td>
<td>_____ Minutes</td>
</tr>
<tr>
<td>☐ 2 ☐ 6</td>
<td>_____ Hours</td>
</tr>
<tr>
<td>☐ 3 ☐ 7</td>
<td></td>
</tr>
<tr>
<td>☐ 4</td>
<td></td>
</tr>
</tbody>
</table>

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.

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

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

<table>
<thead>
<tr>
<th>Currently Receiving</th>
<th>Interested in Receiving</th>
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<tbody>
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</tbody>
</table>

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

### Social Services

<table>
<thead>
<tr>
<th>Currently Receiving</th>
<th>Interested in Receiving</th>
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<tbody>
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</table>

- Social Work services
- Housing services (e.g. subsidized housing, discrimination, landlord disputes, homelessness)
- Care coordination
- Legal advocacy

### Financial Services

<table>
<thead>
<tr>
<th>Currently Receiving</th>
<th>Interested in Receiving</th>
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- Savings
- Social Security Disability Insurance (SSDI)
- Social Security Retirement benefits
- Medicare
- Retirement Income/Pension
- MediCal
- In-Home Supportive Services (IHSS; MediCal only program)
- Long term care insurance
- Supplemental Security Income
- Other income (e.g. trust, annuity)
- VA Benefits

Alzheimer's and Dementia Care Program, last revision 9/16
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 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)

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/](http://dementia.uclahealth.org/)

Alzheimer’s and Dementia Care Program, last revision 9/16