Dementia Singapore

REFERRAL FORM FOR DEMENTIA SOCIAL CLUB

Please fax this referral form to :

- ☐ Dementia Social Club @Tiong Bahru (298 Tiong Bahru Road #10-05 Central Plaza) **FAX: 6273 0996**
  I/C : Ms Ivy Ong; Tel : 6389 5389 / 8333 6467 or email : ivy.ong@dementia.org.sg

PARTICULARS OF CLIENT

Name ____

NRIC No. ____________________ **Sex** *F / M* **Date of Birth** ____________________

Address ____ **Postal code (** **)**

Marital Status *Single / Married / Divorced / Separated / Widowed*

Race *Chinese / Malay / Indian / Others* ______________________________

Preferred Spoken Language *English / Mandarin / Hokkien / Cantonese / Teochew / Malay / Tamil / Others* ______________________________

Citizenship *Singaporean / PR / Foreigner*

PARTICULARS OF CONTACT PERSON / CAREGIVER

Name ____________________ **Sex** *F / M* **Relationship to client** ____________________

Contact Numbers ***Home*** ____________________ ***Office*** ____________________

Mobile ____________________ ***Email*** ______________________________

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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 (Please tick ☑):

☐ Alzheimer's Disease ☐ Vascular ☐ Mixed ☐ ________________________________

Stage of Dementia (Please tick ☑):

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

Dementia Follow-up

☐ Yes (Please provide details below) ☐ No

Doctor's Name ________________________________ Designation ______________________

Hospital / Clinic ________________________________ Next TCU date (*if applicable*) ____________

Presenting Problem(s) – *Cognitive and Behavioural (e.g. of behavioural problems – aggression, apathy, shouting, sleep disturbance, wandering, etc.)*

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Other Medical Condition(s) & Summary of Investigations and Management

(*Please attach memo if insufficient space*)

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Medications / Dosage / Frequency

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Drug Allergies ☐ No ☐ Yes (*please specify*: ____________________________________)

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 Please tick ☑

a) Mobility : (i) ☐ Ambulant ☐ Semi-ambulant

(ii) Use of walking aids: ____________________________________

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

c) Self-Care :

(i) Toileting : ☐ Independent ☐ Need Supervision ☐ Need Assistance

(ii) Dressing : ☐ Independent ☐ Need Supervision

(iii) Feeding : ☐ Independent ☐ Need Supervision

d) Visual impairment : ☐ Yes ☐ No

e) Hearing impairment : ☐ Yes ☐ No

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SECTION D. REFERRING DOCTOR

Name ______________________________ Designation ______________________

Contact No. ____

Email ____

Hospital / Clinic / Ward ____

Signature of referring doctor ______________________________ Date __________________

SECTION E. SOCIAL HISTORY: (INCLUDING MAIN CAREGIVER)

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SECTION F. ADDITIONAL DETAILS / INFORMATION

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Latest AMT / MMSE score : ____________ (Date done : ______________________)

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SECTION G. PARTICULARS OF NURSE CLINICIAN / STAFF NURSE COMPLETING THE FORM

Name ________________________________ Designation ___________________________________

Contact No. ____

Email ____

Hospital / Clinic / Ward ____

Signature of Nurse Clinician / Staff Nurse ___________________________ Date ______________________

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 Dementia Singapore (DSG) for the purpose of the doctor/hospital/clinic referring the client named on page 1 to DSG's Dementia Social Club and
- DSG collecting and using the personal data in this Referral form for the purposes of contacting me about admission of the client to that programme and
- DSG collecting and using any personal data obtained by observation of the client in any face-to-face meeting with DSG to consider their admission to Dementia Social Club

Signature of Contact person/Caregiver ______________________________ Date ______________________