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 Wong Sze Chi ; Tel : 6389 5110 / 8764 4934 or email : szechi.wong@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.)*

_____

_____

_____

_____

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

(*Please attach memo if insufficient space*)

_____

_____

_____

_____

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Medications / Dosage / Frequency

_____

_____

_____

_____

_____

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)

_____

_____

_____

_____

_____

_____

SECTION F. ADDITIONAL DETAILS / INFORMATION

_____

_____

_____

_____

_____

_____

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

SECTION G. PARTICULARS OF NURSE CLINICIAN / STAFF NURSE

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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 _____