REFERRAL FORM FOR FAMILY OF WISDOM

This is a **three-hour enrichment programme** that is conducted in a small group setting. Where persons with dementia are grouped according to their stage of dementia, preferred spoken language, age, educational profile and gender (for clients with moderate dementia onwards). Each group size varies and is facilitated by 3 to 5 staff. The session provides a continuum of community care for persons with dementia who have completed sessional therapy outpatient programmes and are discharged for community care.

Each session has a combination of cognitive and physically stimulating activities, designed with a social element to foster greater interaction and promote neurogenesis for persons with dementia. The session complements a full-day dementia daycare programme with shorter hours.

Please fax / scan this referral form to :

Family of Wisdom (Bendemeer)

Address : 20 Bendemeer Road #01-02 BS Bendemeer Centre, Singapore 339914)

Attention : Ms Eunice Tan; Tel: 63895385 / 83334080, **FAX: 62936631** or email : eunice.tan@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*** _____

NOTE: SECTION A, B & C to be completed by Medical Doctor / Nurse Clinician with consent from family caregiver ☐ Yes ☐ No

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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*)

_____

_____

_____

_____

Medications / Dosage / Frequency

_____

_____

_____

_____

_____

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

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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

SECTION D. REFERRING DOCTOR

Name _____ Designation _____

Contact No. _____

Email _____

Hospital / Clinic / Ward _____

Signature of referring doctor _____

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 COMPLETING THE FORM

Name _____ Designation _____

Contact No. _____

Email _____

Hospital / Clinic / Ward _____

Signature of Nurse Clinician / Staff Nurse _____

REFERRAL FORM FOR FAMILY OF WISDOM

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 Family of Wisdom programme 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 the Family of Wisdom programme

_____ _____

Signature of contact person/caregiver named on page 1 Date