Alzheimer's and Dementia Care Program
200 UCLA Medical Plaza, Suite 365A
Los Angeles, CA 90095
dementia@mednet.ucla.edu
(310)319-3222

We are looking forward to seeing you and your loved one for an annual visit with their Dementia Care Manager with our Alzheimer's and Dementia Care Program.

Please find attached the following forms to be completed by the caregiver/patient.

- Forms to be filled out by the patient or caregiver, regarding the **patient** *over the course of the last year*:
  - Form C1 - Follow up Questionnaire
  - Form C3 - Evaluation for Problematic Behaviors (NPI-Q)

Please make sure to bring the completed forms to your visit. If you are unable to fill them out beforehand, we ask you arrive at your appointment 30 minutes earlier, to do so.

It is very important to have at least one family member/caregiver at the appointment.

If you have any questions about your appointment or the forms, please feel free to contact us at dementia@mednet.ucla.edu or (310) 319-3222.

Sincerely,

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

UCLA Health

MRN:
Patient Name:

Alzheimer's and Dementia Care Program
FOLLOW-UP 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.

1. Date form completed: ____ / ____ / _____
MM DD YYYY

2. Name of patient: _____ _____
Last First

3. Who filled out this form?

☐ Patient (Skip to question 4) ☐ 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? _____

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

4. PRIMARY CARE PHYSICIAN & SPECIALISTS

Have you changed your Primary Care Physician and/or seen a new specialist for your dementia related symptoms (e.g. Psychiatrist, Geriatrician, Neurologist, etc)?

☐ Yes ☐ No (skip to question 5)

Name: _____

Specialty: _____

Address: _____ _____
Street Suite

_____ _____ _____
City State Zip

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

5. ALLERGIES

Do you have any new drug allergies? ☐ Yes ☐ No

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

Name of Drug	Describe Reaction
1.	
2.	

6. MEDICATIONS

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.		

7. NON-UCLA: EMERGENCY VISITS

Please list all non-UCLA visits in the last 12 months.

Type (ER / UC / H / SN)	Reason for visit	Hospital / Medical Center	Month / Year	*If applicable:* Length of stay

8. Daily Activities

Please check the most appropriate box for each task

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

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

9. RESOURCES AND SERVICES *In the past year:*

A. Any changes in living situation?

1. ☐ Yes ☐ No (Skip to question B)

If yes, please provide new address:

_____ _____
Street Apartment

_____ _____ _____
City State Zip

2. With whom do you live? (Check all that apply)
   - ☐ Alone
   - ☐ Spouse or Partner
   - ☐ Child
   - ☐ Other family member (specify): _____
   - ☐ Others, not family (specify): _____

3. Which of the following best describes your residence:
   - ☐ Single-family house
   - ☐ Condo
   - ☐ Apartment
   - ☐ Board & Care/Assisted living
   - ☐ Nursing Home
   - ☐ Other (specify): _____

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

1. ☐ Yes ☐ No (Skip to question C)
2. 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 a week)

3. Is this an increase from last year? ☐ Yes ☐ No
4. Is this sufficient to meet your needs? ☐ Yes ☐ No

C. Do you get help from family members or friends in your home?

1. ☐ Yes ☐ No (Skip to question D)
2. 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)
3. Is this an increase from last year? ☐ Yes ☐ No
4. Is this sufficient to meet your needs? ☐ Yes ☐ No
5. Please name family/friend that provides help: _____
6. If this family/friend were to get sick or hospitalized, who would provide help?

   _____

D. Who would you 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.		☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other _____	☐ Yes ☐ No
2.		☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other _____	☐ Yes ☐ No
3.		☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other _____	☐ Yes ☐ No

E. Outside of UCLA, is anybody (agency or person) helping you get the information or services you need? ☐ Yes ☐ No

If yes, how often?

☐ Monthly ☐ Every 3 months ☐ Every 6 months ☐ As needed ☐ Not at all

Which organizations?

_____

_____

_____

_____

F. Please check the appropriate box for each service (Caregiver, Day-to-Day, Social) to indicate the services you are currently receiving and what services *if any,* you would be interested in receiving.

Day-To-Day Services

Currently receiving	Interested in receiving	
☐	☐	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

Currently receiving	Interested in receiving	
☐	☐	Social Work services
☐	☐	Housing services (e.g. subsidized housing, discrimination, landlord disputes, homelessness)
☐	☐	Care coordination
☐	☐	Legal advocacy

Financial Services

Currently receiving	Interested in receiving	
☐	☐	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

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

H. 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

I. 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)

10. 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/