Alzheimer's and Dementia Care Program
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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 (NPI-Q)

  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

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MRN:
Patient Name:
DOS:

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: (_____) ______ - ___________

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DOS:

11. ALLERGIES

Do you have any drug allergies? ☐ Yes ☐ No

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

Name of Drug	Describe Reaction
1.	
2.	

12. 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.		

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13. PAST MEDICAL HISTORY

Which medical conditions do you have now or have had in the past?
(Please check all that apply)

EYE & EAR

- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss/hearing aid
- ☐ Other (specify): ____________

HEART

- ☐ Heart attack, year: __________
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Aortic stenosis
- ☐ Heart valve problem
- ☐ Angina
- ☐ High cholesterol
- ☐ Pacemaker
- ☐ Atrial fibrillation
- ☐ Irregular heartbeats (arrhythmias)
- ☐ Other (specify): ____________

GASTROINTESTINAL TRACT

- ☐ Heartburn/reflux/GERD
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Liver disease/cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Colon polyps
- ☐ Diverticulosis
- ☐ Bleeding problems
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Other (specify): ____________

LUNGS

- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Recurrent pneumonias
- ☐ Other (specify): ____________

KIDNEY & URINARY TRACT

- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Enlarged prostate
- ☐ Urinary incontinence
- ☐ Kidney stones
- ☐ Other (specify): ____________

BONES & JOINTS

- ☐ Gout
- ☐ Lower back pain
- ☐ Osteoporosis
- ☐ Arthritis (indicate location):
  - ☐ hip ☐ knee
  - ☐ shoulder ☐ back
  - ☐ hands
- ☐ Fractured bone (indicate location):
  - ☐ hip ☐ spine ☐ wrist
  - ☐ Other (specify): ____________

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PAST MEDICAL HISTORY cont.

GLANDS

☐ Thyroid overactive (high)
☐ Thyroid underactive (low)
☐ Diabetes
☐ Other (specify): ____________

NERVOUS SYSTEM

☐ Epilepsy or seizures
☐ Neuropathy/nerve damage
☐ Stroke
☐ Other (specify): _____________
☐ Parkinson's disease

OTHER HEALTH PROBLEMS

☐ Thrombosis/blood clots: ☐ in the leg ☐ in the lung
☐ Syncope (loss of consciousness)
☐ Sexual function problems (specify): _________________________
☐ Cancer: ☐ Breast ☐ Skin ☐ Prostate
☐ Lymphatic ☐ Colon/rectum ☐ Lung
☐ Other (specify): __________________________

14. HOSPITALIZATIONS/SKILLED NURSING VISITS

Please list all hospitalizations including neuropsychiatric hospitalizations for the last 5 years.

Which Hospital/Skilled Nursing Facility?	Reason for Hospitalization/SNF Visit	Year

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15. Do you have access to a medical professional for advice on dementia-related issues <u>at all times</u> (24 hours a day/7 days a week?) ☐ Yes ☐ No

16. 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): ____________________

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.____________________

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I. Who would you (the patient) call if you were sick and needed help? (check all that apply)

☐ Spouse/Partner ☐ Daughter ☐ Son
☐ Neighbor ☐ Friend ☐ Other (specify): ________________

1. Please list name(s) and phone number(s):

Name:______________________________ Phone number: (_____) _____ - _________

Name:______________________________ Phone number: (_____) _____ - _________

Name:______________________________ Phone number: (_____) _____ - _________

2. Do we have permission to speak to the person(s) listed above on your (the patient's) behalf?
☐ Yes ☐ No

J. Do you employ 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

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M. 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, which ones:

☐ Bicycling or stationary bike
☐ Aerobics or exercise classes
☐ Dancing ☐ Jogging
☐ Walking ☐ Swimming
☐ Tennis ☐ Golf
☐ Bowling or bocce ☐ Yoga
☐ Pilates ☐ Other (specify): ________________

Days per week	Amount of time per day
☐1 ☐5 ☐2 ☐6 ☐3 ☐7 ☐4	_____ Minutes _____ Hours

17. PATIENT FAMILY HISTORY

A. Have any members of your family had memory problems? ☐ Yes ☐ No

18. DRIVING

A. Do you have a valid Driver's License? ☐ Yes ☐ No
B. If yes, are you currently driving? ☐ Yes ☐ No

19. SAFETY

A. Do you always wear a seat belt when you ride in a car? ☐ Yes ☐ No
B. Do you own any firearms? ☐ Yes ☐ No
C. Are there any firearms in your home? ☐ Yes ☐ No
D. Do you have a history of wandering or getting lost while outside of the home?
☐ Yes ☐ No

20. 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

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21. 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 or medicines	☐	☐	
Shopping for groceries	☐	☐	
Driving	☐	☐	
Climbing a flight of stairs	☐	☐	
Getting to places beyond walking distance (e.g. by bus, taxi, or car)	☐	☐	

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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

If yes, please describe the circumstances surrounding the fall:

Did you trip over something?	☐ Yes	☐ No
Did you have lightheadedness or palpitation prior?	☐ Yes	☐ No
Did you lose consciousness?	☐ Yes	☐ No
Were you injured?	☐ Yes	☐ No
Did you need to see a doctor?	☐ Yes	☐ No
Were you able to get up by yourself?	☐ Yes	☐ No

22. 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
- ☐ Itching
- ☐ Easy bruising

E. Lung Problems
- ☐ Cough when eating
- ☐ Difficulty breathing or shortness of breath

F. Mood/Sadness Problems
- ☐ Depression
- ☐ Anxiety
- ☐ Sleepiness
- ☐ Fatigue
- ☐ Lack of sleep

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G. Heart problems

- ☐ Chest pain or tightness
- ☐ Lightheadedness
- ☐ Irregular heart beat
- ☐ Rapid heart beat

H. Bone and Joint Problems

- ☐ Leg pain on walking
- ☐ Back or neck pain
- ☐ Joint pain or stiffness
- ☐ Foot problems
- ☐ Balance problems
- ☐ Falls

I. 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
- ☐ Problems with sleep
- ☐ Hallucinations
- ☐ Delusions (false beliefs)

J. Digestive Problems

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Frequent indigestion or heartburn
- ☐ Frequent nausea or vomiting
- ☐ Persistent constipation
- ☐ Frequent diarrhea
- ☐ Bleeding from rectum
- ☐ Black bowel movement

K. 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
  If yes:
  - ☐ Sudden urge to void
  - ☐ Loss with cough or laughing
  - ☐ Continuous leakage
  - ☐ Hard to start urination
  - ☐ Cannot empty bladder
  - ☐ Problem getting to toilet

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23. Access to Resources & Services

A. Is anybody outside of UCLA helping you get information or services you need?

☐ Yes ☐ No

B. What outside services have you received in the past? *(List all)*

____

____

C. 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

Currently receiving	Interested in receiving	
☐	☐	Transportation (e.g. subsidies, public, door-to-door services)
☐	☐	Nutrition Services (meal delivery, shopping, meal preparation)
☐	☐	Supplies (e.g. toiletries, clothing, etc.)
☐	☐	Housekeeping
☐	☐	Medications management
☐	☐	Adult Day Care services
☐	☐	Access to communication (e.g. TTY, instruments for the hearing impaired)
☐	☐	Work accommodation (e.g. flexible hours, job modification)
☐	☐	Home Health Care
☐	☐	Home safety modification (e.g. bathroom bars, commodes, etc.)

Social Services

Currently receiving	Interested in receiving	
☐	☐	Benefits Counseling (e.g. MediCare Part D, Supplemental Security Income, Social Security)
☐	☐	Financial counseling (e.g. money mgmt, debt or foreclosure counseling)
☐	☐	Social Work services
☐	☐	Housing services (e.g. subsidized housing, discrimination, landlord disputes, homelessness)
☐	☐	Care coordination
☐	☐	Veteran’s services
☐	☐	Legal advocacy

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DOS:

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 (state funded program)

D. 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

E. 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

24. 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)

4)

5)

THANK YOU FOR COMPLETING THIS FORM

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