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)
  - Form C4 - Functional Assessment Questionnaire
- Forms to be filled out by the caregiver, regarding the **caregiver** *over the course of the last year*:
  - Form C2 - Follow up Caregiver Rating of Dementia Care and Self-Efficacy
  - Form C5 - Modified Caregiver Strain Index

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

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/

NPI-Q

Patient Name:_____

Completed by:_____

Date:_____

Office Use Only
Form C3

Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. **Mark "Yes" only if the symptom(s) has been present in the last month.** For each item marked "Yes", please mark:

SEVERITY of the symptom (how it affects the patient):	**DISTRESS** you experience due to that symptom (how it affects you):
1 = Mild (noticeable, but not a significant change) **2 = Moderate** (significant, but not a dramatic change) **3 = Severe** (very marked or prominent, a dramatic change)	**0 = Not distressing at all** **1 = Minimal** (slightly distressing, not a problem to cope with) **2 = Mild** (not very distressing, generally easy to cope with) **3 = Moderate** (fairly distressing, not always easy to cope with) **4 = Severe** (very distressing, difficult to cope with) **5 = Extreme or very severe** (extremely distressing, unable to cope)

Please answer each question carefully. Ask for assistance if you have any questions.

Delusions
Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?
Comments:

☐ **YES** ☐ **NO (go to next question)**

SEVERITY **1** ☐ **2** ☐ **3** ☐

DISTRESS **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐

Hallucinations
Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present?
Comments:

☐ **YES** ☐ **NO (go to next question)**

SEVERITY **1** ☐ **2** ☐ **3** ☐

DISTRESS **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐

Agitation/Aggression
Is the patient resistive to help from others at times, or hard to handle?
Comments:

☐ **YES** ☐ **NO (go to next question)**

SEVERITY **1** ☐ **2** ☐ **3** ☐

DISTRESS **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐

Depression/Dysphoria
Does the patient seem sad or say that he /she is depressed?
Comments:

☐ **YES** ☐ **NO (go to next question)**

SEVERITY **1** ☐ **2** ☐ **3** ☐

DISTRESS **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐

Anxiety
Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense? ***Comments:***

☐ **YES** ☐ **NO (go to next question)**

SEVERITY **1** ☐ **2** ☐ **3** ☐

DISTRESS **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐

Elation/Euphoria
Does the patient appear to feel too good or act excessively happy?
Comments:

☐ YES ☐ NO (go to next question)

SEVERITY 1 2 3 ☐ ☐ ☐

DISTRESS 0 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐ ☐

Apathy/Indifference
Does the patient seem less interested in his/her usual activities or in the activities and plans of others?
Comments:

☐ YES ☐ NO (go to next question)

SEVERITY 1 2 3 ☐ ☐ ☐

DISTRESS 0 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐ ☐

Disinhibition
Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them, or saying things that may hurt people's feelings?
Comments:

☐ YES ☐ NO (go to next question)

SEVERITY 1 2 3 ☐ ☐ ☐

DISTRESS 0 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐ ☐

Irritability/Lability
Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?
Comments:

☐ YES ☐ NO (go to next question)

SEVERITY 1 2 3 ☐ ☐ ☐

DISTRESS 0 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐ ☐

Motor Disturbance
Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?
Comments:

☐ YES ☐ NO (go to next question)

SEVERITY 1 2 3 ☐ ☐ ☐

DISTRESS 0 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐ ☐

Nightime Behaviors
Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?
Comments:

☐ YES ☐ NO (go to next question)

SEVERITY 1 2 3 ☐ ☐ ☐

DISTRESS 0 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐ ☐

Appetite/Eating
Has the patient lost or gained weight, or had a change in the type of food he/she likes?
Comments:

☐ YES ☐ NO (go to next question)

SEVERITY 1 2 3 ☐ ☐ ☐

DISTRESS 0 1 2 3 4 5 ☐ ☐ ☐ ☐ ☐ ☐

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

YEAR 1

Patient Name:_____

Completed by:_____

Date: _____

Office Use Only
Form C4

Please check the answer that best represents the patient's functional ability.
0 = Normal, 1 = Has difficulty, 2 = Requires assistance, 3 = Dependent

In the past 4 weeks, did the patient have any difficulty or need help with:

	Not applicable	Normal	Has difficulty, but does by self	Requires assistance	Dependent
1. Writing checks, paying bills, or balancing a checkbook	☐	☐	☐	☐	☐
2. Assembling tax records, business affairs or papers	☐	☐	☐	☐	☐
3. Shopping alone for clothes, household necessities or groceries	☐	☐	☐	☐	☐
4. Playing a game of skill or working on a hobby	☐	☐	☐	☐	☐
5. Heating water, making a cup of coffee, or turning off the stove	☐	☐	☐	☐	☐
6. Preparing a balanced meal	☐	☐	☐	☐	☐
7. Keeping track of current events	☐	☐	☐	☐	☐
8. Paying attention to, understanding or discussing a TV program, book or magazine	☐	☐	☐	☐	☐
9. Remembering appointments, family occasions, holidays or medications	☐	☐	☐	☐	☐
10. Traveling out of the neighborhood, driving or arranging to take buses	☐	☐	☐	☐	☐
				SCORE:	

CAREGIVER RATING OF DEMENTIA CARE AND SELF-EFFICACY

Office Use Only
Form C2

Please answer the following questions about yourself. Please mark the boxes (☒) that apply to you.

1. What is your date of birth? (MM/DD/YYYY) ____ / ____ / _____

2. What is your gender?
☐ Male ☐ Female

3. How much school did you complete?
☐ Less than 8th grade
☐ Some high school
☐ High school graduate
☐ Some college
☐ College graduate
☐ Graduate school

4. You are presently:
☐ Single or never married ☐ Married
☐ Living with a partner ☐ Divorced or separated
☐ Widowed

5. What is your relationship to the patient?
☐ Spouse or partner ☐ Child
☐ Friend ☐ Hired or paid caregiver
☐ Other family member:
please specify _____
☐ Other:
please specify _____

6. Do you live with the patient?
☐ Yes ☐ No

7. In general, would you say your health is:
☐ Excellent ☐ Very good
☐ Good ☐ Fair
☐ Poor

8. What is your ethnicity?
☐ Hispanic or Latino ☐ Not Hispanic or Latino

9. What is your race?
☐ American Indian or Alaskan Native
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ White
☐ Other (please specify: _____)

10. Did you fill out this survey at the initial program visit one year ago?

☐ Yes ☐ No

Please indicate whether you agree or disagree with each of the following statements about the patient's memory condition and your experiences with the patient's care up to now.
*Please put an "**X**" in the columns that apply to you.*

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The patient's regular doctor understands how memory or behavior problems complicate other health conditions.	☐	☐	☐	☐	☐
2. I have received advice about handling problems like the patient's memory loss, wandering or behavior problems.	☐	☐	☐	☐	☐
3. I have received advice about what problems to expect in the future related to Alzheimer's or dementia.	☐	☐	☐	☐	☐
4. I am aware of services available to me to help me provide care.	☐	☐	☐	☐	☐
5. I feel confident that I can handle problems like the patient's memory loss, wandering or behavior problems.	☐	☐	☐	☐	☐
6. I know where to turn to get answers to questions about memory problems like the patient's memory loss, wandering, or behavior problems.	☐	☐	☐	☐	☐
7. I know how to get community services that will help me provide care.	☐	☐	☐	☐	☐
8. I feel confident that I can deal with the frustrations of caregiving.	☐	☐	☐	☐	☐
9. I have a healthcare professional who helps me work through dementia care problems.	☐	☐	☐	☐	☐

MODIFIED CAREGIVER STRAIN INDEX

YEAR 1

Caregiver Name:_____

Date: _____

Office Use Only
Form C5

Directions: Here is a list of things that other caregivers have found to be difficult. We have included some examples that are common caregiver experiences to help you think about each item. Your situation may be slightly different, but the item could still apply.

	Yes, On a regular basis	Yes, Sometimes	No
1. My sleep is disturbed (For example: the person I care for is in and out of bed or wanders around at night)	☐	☐	☐
2. Caregiving is inconvenient (E.g.: helping takes so much time or it's a long drive over to help)	☐	☐	☐
3. Caregiving is a physical strain (E.g.: lifting in or out of a chair, effort or concentration is required)	☐	☐	☐
4. Caregiving is confining (E.g.: helping restricts free time or I cannot go visiting)	☐	☐	☐
5. There have been family adjustments (E.g.: helping has disrupted my routine; there is no privacy)	☐	☐	☐
6. There have been changes in personal plans (E.g.: I had to turn down a job; I could not go on vacation)	☐	☐	☐
7. There have been other demands on my time (For example: other family members need me)	☐	☐	☐
8. There have been emotional adjustments (E.g.: severe arguments about caregiving)	☐	☐	☐
9. Some behavior is upsetting (E.g.: incontinence; the person cared for has trouble remembering things; or the person I care for accuses people of taking things)	☐	☐	☐
10. It is upsetting to find the person I care for has changed so much from his/her former self (E.g.: he/she is a different person than he/she used to be)	☐	☐	☐
11. There have been work adjustments (E.g.: I have to take time off for caregiving duties)	☐	☐	☐
12. Caregiving is a financial strain	☐	☐	☐
13. I feel completely overwhelmed (E.g.: I worry about the person I care for; I have concerns about how I will manage)	☐	☐	☐

SCORE: ☐