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

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

    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

UCLA Health System

MRN:
Patient Name:
DOS:

Form B1

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? _____

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: (_____) _____ - _____

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

Have you ever been prescribed dementia medications? ☐ Yes ☐ No

If yes, please check all appropriate boxes

☐ Aricept (Donepezil) ☐ Namenda (Memantine) ☐ Axona

☐ Exelon (Rivastigmine) ☐ Razadyne (Galantamine)

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.		

13. HOSPITALIZATIONS/SKILLED NURSING VISITS

Please list all hospitalizations including neuropsychiatric hospitalizations *outside* UCLA for the last 2 years.

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

14. 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): _____

1. Do you: ☐ Own ☐ Rent
2. How long have you lived there?

   _____
3. What floor do you live on? _____
4. Do you take the stairs? ☐ Yes ☐ No
   If yes, how many steps? _____

C. You are presently:

- ☐ Single/Never married
- ☐ Married
- ☐ Divorced/Separated
- ☐ Widowed
- ☐ Living with significant other

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._____

I. Who would you (the patient) 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

J. Do you pay 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

M. Do you currently smoke? ☐ Yes ☐ No

N. Have you ever used or abused drugs? ☐ Yes ☐ No ☐ Unknown

O. Are you sexually active? ☐ Yes ☐ No ☐ Unknown

P. 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, please list all activities:

_____
_____
_____
_____
_____

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

15. PATIENT FAMILY HISTORY

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

16. DRIVING

A. Do you have a valid Driver's License? ☐ Yes ☐ No

B. If yes, are you currently driving? ☐ Yes ☐ No

17. SAFETY

A. Are there any firearms in your home? ☐ Yes ☐ No

B. Do you have a history of wandering or getting lost while outside of the home? ☐ Yes ☐ No

18. 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

19. 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

20. 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

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

F. Heart problems
- ☐ Chest pain or tightness
- ☐ Lightheadedness
- ☐ Irregular heart beat
- ☐ Rapid heart beat

G. 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

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

I. 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

21. Access to Resources & Services

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)
☐	☐	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

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

B. 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

C. 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)

22. 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 B2

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 <u>month</u>.** For each item marked "Yes", please mark:

SEVERITY of the symptom (how it affects <u>the patient</u>):	**DISTRESS** you experience due to that symptom (how it <u>affects you</u>):
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.

<u>Delusions</u>
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** ☐

<u>Hallucinations</u>
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** ☐

<u>Agitation/Aggression</u>
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** ☐

<u>Depression/Dysphoria</u>
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** ☐

<u>Anxiety</u>
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 ☐ ☐ ☐ ☐ ☐ ☐
