

DEMENTIA CAREGIVER RESILIENCE CLINIC REFERRAL FORM



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Geriatric Medicine Referral

The focus of the Dementia Caregiver Resilience Clinic is to support building of skills to optimize dementia caregiver confidence, competence, self-care, and resilience. Based on individual needs, group or one-to-one services may be offered. If you are seeking an ongoing support group, please visit the Alzheimer Society of BC or Family Caregivers of BC websites for further information.

Instructions: **PLEASE COMPLETE THIS FORM AND FAX TO (604-806-8390), MAIL, OR DROP OFF: Attention: Dementia Caregiver Resilience Clinic, 9B ST. PAUL'S HOSPITAL, 1081 BURRARD St, VANCOUVER BC, V6Z 1Y6**

Intake Information and Consent

PART 1 - TO BE COMPLETED BY THE CAREGIVER		
Caregiver name: _____		
Personal Health Number (PHN): _____	DOB: (dd/mmm/yyyy) _____	
Primary Language: _____		Interpreter required <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone: _____	Is it ok to leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	Alternate phone: _____
Can we contact you by email <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, email address: _____		
Name of Family Physician or Nurse Practitioner: _____		
Referral Source: <input type="checkbox"/> Self-referral <input type="checkbox"/> Family Physician/Nurse Practitioner <input type="checkbox"/> Other: _____		
The person with dementia is my: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Other: _____		
Is this person being seen in the Elder Care Clinic? <input type="checkbox"/> No <input type="checkbox"/> Yes, by Dr. _____		
When did this person receive a diagnosis of dementia? (dd/mmm/yyyy) _____		
Type of dementia, if known? _____		
Who suggested the Dementia Caregiver Resilience Clinic to you? _____		
I am already connected to the Alzheimer Society of BC: <input type="checkbox"/> Yes <input type="checkbox"/> No		
CONSENT		
<input type="checkbox"/> I consent to be contacted for a 15 minute introductory phone call.		
<input type="checkbox"/> If it is determined that I would benefit from meeting with Dr. Susan More or Dr. Elisabeth Drance (geriatric psychiatrists) for my intake assessment, I consent to a referral being requested from my family doctor/nurse practitioner.		
<input type="checkbox"/> I consent to the Dementia Caregiver Resilience team sharing information with my family doctor/nurse practitioner.		
Caregiver signature: _____ Date: (dd/mmm/yyyy) _____		

PART 2 – Health History – to be completed by caregiver or family doctor/nurse practitioner	
CAREGIVER'S HEALTH HISTORY (past and ongoing illness, surgery, mental health challenges) <input type="checkbox"/> attached	CAREGIVER MEDICATION LIST: _____ _____ _____ _____ _____ _____ _____ _____



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PART 3 – TO BE COMPLETED BY THE CAREGIVER

SCREENING QUESTIONNAIRE

Your answers to this questionnaire will be used to assist the clinic team to better understand your needs as a caregiver so that we may offer services that will be most helpful to you.

Please choose the best answer for the statements below.

1	During my life, I have had periods of depression or anxiety that made it hard for me to function day to day.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	We had a stressful family life before my family member's dementia. The illness is making these problems worse than before.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	My family member has more than one dementia-related behaviour. (e.g. anxiety, apathy, verbal or physical aggression, getting lost, refusing care)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	When I am trying to help or support my family member with dementia, we often argue.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	I feel uncertain about what to do and how to best care for my family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6	I feel stressed by trying to meet my caregiving, work, and family responsibilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7	Because of the time I spend caring for my family member I don't have enough time for myself.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8	My family member will soon be, or has moved into a residential care home, and this transition is tough for me.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9	What are your main caregiving challenges? What are your hopes for involvement in the Dementia Caregiver Resilience Clinic? <hr/> <hr/> <hr/> <hr/> <hr/>		