Dementia Singapore

Caregiver Support Services Referral Form

SOURCE OF REFERRAL

Date: _____

Name / Designation: _____ **Organisation / Department:** _____

Contact No.: _____ **Fax No.:** _____ **Email Address:** _____

Service(s) Required:

☐ **Home Support Team**
Provides support for behaviours of concern, counselling, and case management.

☐ **Eldersit Service**
Provides meaningful home-based activity engagement for Persons with Dementia and respite for caregivers.

PRESENTING NEEDS/ ISSUES *(Please Tick Accordingly)*

☐ Develop coping strategies on behaviours of concern *(please select sub-option)*
- ☐ Caregiver requires some support to adapt strategies in managing current behaviours of concern.
- ☐ Caregiver is having difficulty adapting strategies to current behaviours of concern.

☐ Caregiver stress due to caregiving *(please select sub-option)*
- ☐ High Stress
- ☐ Moderate Stress
- ☐ Low Stress

☐ Grief and loss issues related to caregiving

☐ Psychoeducation on dementia and caregiving needs

☐ Navigation and linkage of dementia services

☐ Activity engagement for persons with dementia at home

☐ Risk related matters i.e. alleged abuse and/or suicidal ideation

☐ Others (_____)

CONFIRMATION OF CONSENT

I confirm that the main caregiver named in this Caregiver Support Services Referral Form has consented to us providing their personal data and person with dementia's latest hospital discharge summary/medical memo to Dementia Singapore for the purpose of this referral.

_____ _____

(Signatory of referring staff) (Date)

Updated 1 Sep 2021

Dementia Singapore

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PARTICULARS OF PERSON WITH DEMENTIA

Name (As per NRIC): _____ **NRIC No.:** _____

Date of Birth / Age: _____ **Gender:** _____ **Contact No.:** _____

Address (As per NRIC): _____

Citizenship:
- ☐ Singaporean
- ☐ Singapore PR
- ☐ Others (_____)

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Race:
- ☐ Chinese
- ☐ Malay
- ☐ Indian
- ☐ Eurasian
- ☐ Others (_____)

Religion:
- ☐ Buddhism
- ☐ Christianity
- ☐ Islam
- ☐ Hinduism
- ☐ Others (_____)

Language(s) / Dialect(s) Spoken:
- ☐ English
- ☐ Mandarin
- ☐ Malay
- ☐ Tamil
- ☐ Teochew
- ☐ Hokkien
- ☐ Cantonese
- ☐ Others (_____)

MEDICAL INFORMATION OF PERSON WITH DEMENTIA *(For Doctor's Completion)*

Diagnosis and Type of Dementia:
- ☐ Alzheimer's Disease
- ☐ Multi-infarct / Vascular
- ☐ Others (_____)
- ☐ With medical follow-up (Hospital / Clinic: _____)
- ☐ Without medical follow-up
- ☐ Physical Comorbidities (_____)

Name & Signature of Doctor: _____ **MCR No.:** _____

Hospital / Clinic / Designation: _____ **Date:** _____

Cognitive & Behavioral Symptoms: (Please tick if present)

1. Activity Disturbances:
   - ☐ Wandering
   - ☐ Purposeless Activity
   - ☐ Inappropriate activity
2. Aggressiveness:
   - ☐ Agitation
   - ☐ Verbal Outburst
   - ☐ Physical threats / Violence
3. Affective Disturbances:
   - ☐ Tearfulness
   - ☐ Depressed Mood
   - ☐ Anxieties & Phobia
4. Psychological Symptoms:
   - ☐ Hallucinations
   - ☐ Paranoid / Delusions
   - ☐ Day / Night Disturbances

Updated 1 Sep 2021

Dementia Singapore

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PARTICULARS OF MAIN CAREGIVER

Name (As per NRIC): _____ **NRIC No.:** _____

Date of Birth / Age: _____ **Gender:** _____ **Contact No.:** _____

Address (As per NRIC): _____

Email Address: _____ **Relationship to Person with Dementia:** _____

Citizenship:
- ☐ Singaporean
- ☐ Singapore PR
- ☐ Others (_____)

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Race:
- ☐ Chinese
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FAMILY BACKGROUND & FINANCIAL INFORMATION

(Please attach a Social Report if it is available)

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ADDITIONAL INFORMATION / REMARKS

ILTC Means Test Completed:

☐ Yes ☐ No ☐ Not Applying ☐ NA

(Upon means test completion, please attach together all relevant documents.)

Subsidy eligibility:

☐ Yes (_____ %) ☐ No ☐ NA / Not Administered

REFERRAL OUTCOME *(For Official Use)*

☐ Accepted ☐ Rejected with reason(s) as follows: _____

_____

Date: _____ **Name / Designation:** _____ **Contact No.:** _____

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