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Providence Health Care

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OLDER ADULT PROGRAM
DEMENTIA CAREGIVER RESILIENCE CLINIC
REFERRAL / SELF - REFERRAL FORM

* 8 5 3 6 *

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 ☐ Yes ☐ No	
Phone:	Is it ok to leave a message: ☐ Yes ☐ No	Alternate phone:
Can we contact you by email ☐ Yes ☐ No If yes, email address: _____		
Name of Family Physician or Nurse Practitioner: _____		
Referral Source: ☐ Self-referral ☐ Family Physician/Nurse Practitioner ☐ Other: _____		
The person with dementia is my: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other: _____		
Is this person being seen in the Older Adult Clinic? ☐ No ☐ 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: ☐ Yes ☐ No		

CONSENT

☐ I consent to be contacted for a 15 minute introductory phone call.

☐ 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.

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