

OLDER ADULT PROGRAM DEMENTIA CAREGIVER RESILIENCE CLINIC REFERRAL / SELF - 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 🗌 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 co	ompleted by caregive	ver or fami	ly doctor/nu	rse practitioner		
CAREGIVER'S HEALTH HISTORY			CAREGIVE	R MEDICATION LIST:		
(past and ongoing illness, surgery, m □ attached	iental health challenç	ges)				



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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
	What are your main caregiving challenges? What are your hopes for inv Resilience Clinic?	volvement in the Dem	entia Caregiver
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