UCSF FRESNO ALZHEIMER & MEMORY CENTER

Date: _____

PATIENT: _____ Married/Div/Sep/Wid/ ____ Sex:____ DOB: _____

Address: _____ City/State/Zip:_____

Phone: _____ Primary Language: _____ Military: Y/N _____

CONTACT: _____ Relationship to patient: _____

Address: _____ City/State/Zip Code:_____

Phone: _____ (home) _____ (work) _____ (cell)

PRIMARY CAREGIVER: _____ Relationship to patient: _____

Secondary Caregiver: _____ Relationship to patient: _____

Who primarily referred the patient to the AMC? _____

What are your reasons for coming to the AMC? ☐Diagnosis/recommendations ☐Second Opinion

☐Other: _____

Has a formal diagnosis been made at any time?

If yes, what was the diagnosis? _____ By Whom: _____ Year: _____

Describe the changes/current symptoms you see in patient:

_____ Date of onset: _____

_____

Is patient combative?☐ **Incontinent?**☐ **Anticipated level of cooperation?** _____

Special Needs: ☐Cane ☐Wheelchair ☐Walker ☐Hearing aids ☐Other: _____

Still driving?☐ **Holds valid driver's license?** ☐

Patient's primary care physician: _____

Is primary care physician also the referring party? _____ Physician's specialty: _____

Physician's Address: _____ Phone: _____

_____ Fax: _____

Imaging: CT/MRI Head:◯Yes ◯No *If yes*, where: _____

Health care coverage:

- Θ Medicare - part A (hospital insurance)
- Θ Medicare - part B (medical ins.-doctor visits)
- Θ Medi-Cal (Medicaid)
- Θ SANTE: _____ (HMO)
- Θ Tri-Care
- Θ _____: Other health Insurance

PHARMACY:

Name:_____

Phone: _____

Address:_____

_____

University of California
San Francisco

UCSF

Fresno Medical Education Program

SUMMARY OF UCSF FRESNO ALZHEIMER & MEMORY CENTER NOTICE OF PRIVACY PRACTICES

Alzheimer & Memory Center
2335 E Kashian Ln, #301
Fresno, CA 93701
Tel: 559-227-4810
Fax: 559-227-4167

Loren I. Alving, M.D.
Director
Neurologist

Alex C. Sherriffs, M.D., ABFM
Co-Director
Family Practice

Dzung Trinh, M.D., FACP
Geriatrics

Beverly Chang, M.D.
Psychiatrist

Toni Onkka, LCSW
Social Worker

Andres Sviercovich, MSW
Social Worker

Benicia Goka, M.D.
Neuroscientist

Anna Salazar
Administrative Assistant
Patient Relations

Email:
alz@fresno.ucsf.edu

Website:
www.fresno.ucsf.edu/alzheimer

UCSF Fresno Alzheimer & Memory Center (AMC) has always had privacy and patient confidentiality standards in place to ensure appropriate access or disclosure of protected health information. A new federal law called the Health Insurance Portability and Accountability Act (HIPAA) provides additional safeguards for ensuring that your health information is adequately protected. HIPAA also requires UCSF Fresno AMC to provide you with a Notice of Privacy Practices (Notice), which explains how your health information may be used and disclosed and also explains your rights related to your health information.

The attached Notice explains how UCSF Fresno AMC may use and disclose your protected health information to carry out treatment, payment for services and health care operations. Other reasons to use and disclose your protected health information as permitted or required by law are also referred to in the Notice. The Notice also explains your rights to review and control your **protected health information** and explains the responsibility UCSF Fresno AMC has to protect your information.

_____ _____

Signature of Patient (or individual with assigned Power of Attorney or Conservatorship)

Date

Serving the Central Valley Community Since 1989

Effective Date: February 1, 2018

NOTICE OF PRIVACY PRACTICE

UNIVERSITY OF CALIFORNIA SAN FRANCISCO UCSF
Fresno—Alzheimer & Memory Center

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

UCSF Fresno—Alzheimer & Memory Center
UCSF Fresno—Alzheimer & Memory Center is one of the health care components of the University of California. The University of California health care components consist of the UC medical centers, the UC medical groups, clinics and physician offices, the UC schools of medicine and other UC health professional schools, departments engaged in clinical care, the student health service areas on some campuses, employee health units on some campuses, and the administrative and operational units that are part of the health care components of the University of California.

Our Pledge Regarding Your Health Information
UCSF is committed to protecting medical, mental health and personal information about you ("Health Information"). We are required by law to maintain the privacy of your Health Information; provide you information about our legal duties and privacy practices; and inform you of your rights and the ways in which we may use Health Information and disclose it to other entities and persons.

How We May Use and Disclose Health Information About You
The following sections describe different ways that we may use and disclose your Health Information. Some information; such as certain drug and alcohol information, HIV information, genetic information and mental health information; is entitled to special restrictions related to its use and disclosure. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories. Other uses and disclosures not described in this Notice will be made only if we have your written authorization.

For Treatment. We may use Health Information about you to provide you with medical and mental health treatment or services. We may disclose Health Information about you to doctors, nurses, technicians, students, or other UCSF personnel who are involved in taking care of you at UCSF. For example, a doctor treating you for a broken leg may need to know if

you have diabetes because diabetes may slow the healing process. A doctor treating you for a mental condition may need to know what medications you are currently taking, because the medications may affect what other medications may be prescribed to you. We may also share Health Information about you with other non-UCSF providers. The disclosure of your Health Information to non-UCSF providers may be done electronically through a health information exchange that allows providers involved in your care to access some of your UCSF records to coordinate services for you.

For Payment. We may use and disclose Health Information about you so that the treatment and services you receive at UCSF or from other entities, such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about surgery or therapy you received at UCSF so your health plan will pay us or reimburse you for the surgery or therapy. We may also tell your health plan about a proposed treatment to determine whether your plan will pay for the treatment.

For Health Care Operations. We may use and disclose Health Information about you for our business operations. For example, your Health Information may be used to review the quality and safety of our services, or for business planning, management and administrative services. We may contact you about alternative treatment options for you or about other benefits or services we provide. We may also use and disclose your health information to an outside company that performs services for us such as accreditation, legal, computer or auditing services. These outside companies are called “business associates” and are required by law to keep your Health Information confidential. We may also disclose information to doctors, nurses, technicians, medical and other students, and other UCSF personnel for performance improvement and educational purposes.

Appointment Reminders. We may contact you to remind you that you have an appointment at UCSF.

Fundraising Activities. We may contact you, using the contact information you have provided to us, to provide information about UCSF sponsored activities, including fundraising programs and events. We may use contact information, such as your name, address and phone number, date of birth, physician name, the outcome of your care, department where you received services and the dates you received treatment or services at UCSF. You may opt-out of receiving fundraising information for UCSF by contacting UCSF at **HIPAAOptOut@ucsf.edu, or 1-888-804-4722, or Records Manager, UCSF, Box 0248, San Francisco, CA 94143-0248**.

Hospital Directory. If you are hospitalized, we may include certain limited information about you in the hospital directory. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. This information may include your name,

location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, such as ministers or rabbis, even if they don't ask for you by name. You have the opportunity to limit the release of directory information by telling UCSF Admissions Department at the time of your hospitalization.

Our disclosure of this information about you if you are hospitalized in a psychiatric hospital will be more limited.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical care, e.g., a friend, family member, personal representative, or any individual you identify. We may also give information to someone who helps pay for your care. We may also tell your family or friends about your general condition and that you are in the hospital.

Disaster Relief Efforts. We may disclose Health Information about you to an entity assisting in a disaster relief effort so that others can be notified about your condition, status and location.

Research. The University of California is a research institution. We may disclose Health Information about you for research purposes, subject to the confidentiality provisions of state and federal law. All research projects involving patients or the information about living patients conducted by the University of California must be approved through a special review process to protect patient safety, welfare and confidentiality.

In addition to disclosing Health Information for research, researchers may contact you, using the contact information you have provided to us, regarding your interest in participating in certain research studies. Researchers may only contact you if they have been given approval to do so by the special review process. You will only become a part of one of these research projects if you agree to do so and sign a specific permission form called an Authorization. When approved through a special review process, other studies may be performed using your Health Information without requiring your authorization. These studies will not affect your treatment or welfare, and your Health Information will continue to be protected.

As Required By Law. We will disclose Health Information about you when required to do so by federal or state law. This includes releases to the U.S. Department of Health and Human Services, which oversees HIPAA regulations.

To Prevent a Serious Threat to Health or Safety. We may use and disclose Health Information about you when necessary to prevent or lessen a serious and imminent threat to your health

and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Organ and Tissue Donation. If you are an organ donor, we may release your Health Information to organizations that obtain, bank or transplant organs, eyes or tissue, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are or were a member of the armed forces, we may release Health Information about you to military command authorities as authorized or required by law.

Workers' Compensation. We may use or disclose Health Information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

Public Health Disclosures. We may disclose Health Information about you for public health activities such as:

- preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
- reporting vital events such as births and deaths;
- reporting child abuse or neglect;
- reporting adverse events or surveillance related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;

Abuse and Neglect Reporting. We may disclose your Health Information to a government authority that is permitted by law to receive reports of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Proceedings. We may disclose Health Information to courts, attorneys and court employees in the course of conservatorship, writs and certain other judicial or administrative proceedings. We may also disclose Health Information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release Health Information:

- To identify or locate a suspect, fugitive, material witness, certain escapees, or missing person;
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death suspected to be the result of criminal conduct;
- About criminal conduct at UCSF; and
- In case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release Health Information about you to the correctional institution as authorized or required by law.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death. We may also disclose medical information about patients of UCSF to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. As required by law, we may disclose Health Information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. As required by law, we may disclose Health Information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Psychotherapy Notes. *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes have additional protections under federal law and most uses or disclosures of psychotherapy require your written authorization.

Marketing or Sale of Health Information. Uses and disclosures of your Health Information for marketing purposes or any sale of your Health Information are strictly limited and require your written authorization.

Other Uses and Disclosures of Health Information Other uses and disclosures of Health Information not covered by this Notice will be made only with your written authorization. If

you authorize us to use or disclose your Health Information, you may revoke that authorization, in writing, at any time. However, the revocation will not be effective for information that we have already used and disclosed in reliance on the authorization.

Your Rights Regarding Your Health Information
Your Health Information is the property of UCSF. You have the following rights regarding the Health Information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or receive a copy of your Health Information. If we have the information in electronic format then you have the right to get your Health Information in electronic format if it is possible for us to do so. If not, we will work with you to agree on a way for you to get the information electronically or as a paper copy.

You may request that a copy of your Health Information be released to a third party that you designate.

To inspect and/or to receive a copy of your Health Information, you must submit your request in writing to **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 .** If you request a copy of the information, there is a fee for these services.

We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to Health Information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by UCSF will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment or Addendum. If you feel that Health Information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or for UCSF.

Amendment. To request an amendment, your request must be made in writing and submitted to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 phone 1-559-227-4810, fax 1-559-227-4167**. You must be specific about the information that you believe to be incorrect or incomplete and you must provide a reason that supports the request.

We may deny your request for an amendment if it is not in writing, we cannot determine from the request the information you are asking to be changed or corrected, or your request does

not include a reason to support the change or addition. In addition, we may deny your request if you ask us to amend information that:

- Was not created by UCSF;
- Is not part of the Health Information kept by or for UCSF;
- Is not part of the information which you would be permitted to inspect and copy; or
- UCSF believes to be accurate and complete.

Addendum. To submit an addendum, the addendum must be made in writing and submitted to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your Health Information.

To request this accounting of disclosures, you must submit your request in writing to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. Your request must state a time period that may not be longer than the six previous years. You are entitled to one accounting within any 12- month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

To request a restriction, you must make your request in writing to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. We are not required to agree to your request except in the limited circumstance described below. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency care.

We are required to agree to a request not to share your information with your health plan if the following conditions are met:

- We are not otherwise required by law to share the information
- The information would be shared with your insurance company for payment purposes
- You pay the entire amount due for the health care item or service out of your own pocket or someone else pays the entire amount for you

Right to Request Confidential Communications. You have the right to request that we communicate with you about your Health Information in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail.

To request confidential medical communications, you must make your request in writing to Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Copies of this Notice are available throughout UCSF, or you may obtain a copy at our website, http://www.fresno.ucsf.edu/alzheimer-memory-center/..

Right to be Notified of a Breach. You have the right to be notified if we or one of our Business Associates discovers a breach of unsecured Health Information about you.

Changes to UCSF Privacy Practice and This Notice
We reserve the right to change UCSF privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice throughout UCSF. In addition, at any time you may request a copy of the current Notice in effect.

Questions or Complaints
If you have any questions about this Notice, please contact Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167.** If you believe your privacy rights have been violated, you may file a complaint with UCSF or with the Secretary of the Department of Health and Human Services, Office for Civil Rights. To file a written complaint with UCSF, contact Patient Relations, **UCSF Fresno Alzheimer & Memory Center, 2335 E Kashian Ln, #301 Fresno, CA 93701 , phone 1-559-227-4810, fax 1-559-227-4167**. You will not be penalized for filing a complaint.

Effective Date: 2/1/2018

University of California
San Francisco

UCSF

Fresno Medical Education Program

GENERAL INFORMATION

Alzheimer & & Memory Center
2335 E Kashian Ln, #301
Fresno, CA 93701
Tel: 559-227-4810
Fax: 559-227-4167

Loren I. Alving, M.D.
Director
Neurologist

Alex C. Sherriffs, M.D., ABFM
Co-Director
Family Practice

Dzung Trinh, M.D., FACP
Geriatrics

Beverly Chang, M.D.
Psychiatry

Toni Onkka, LCSW
Social Worker
Andres Sviercovich, MSW
Social Worker

Benicia Goka, M.D.
Neuroscientist

Anna Salazar
Administrative Assistant
Patient Relations

Email:
alz@fresno.ucsf.edu

Website:
www.fresno.ucsf.edu/alzheimer

Thank you for choosing the UCSF Fresno Alzheimer & Memory Center (AMC). The AMC is committed to clinical excellence in meeting your health care needs. The following information is provided to answer frequently asked questions concerning the evaluation process. Please call the AMC with any concerns or other questions that you may have.

Diagnostic Testing includes:

- **Family Interview:** Obtaining a detailed history of cognitive and physical changes is critical for an accurate diagnosis.
- **Medical Examinations:** Neurological, physical, and psychiatric examinations may be conducted to identify treatable and contributing medical or psychological conditions.
- **Neuropsychological Assessment:** The pattern of difficulties in thinking abilities is also helpful in determining a diagnosis. The AMC evaluates strengths and weaknesses that are important considerations for treatment and lifestyle planning.
- **Diagnostic Tests:** May be scheduled for the patient at local facilities on an outpatient basis. These can include a CT/MRI scan of the brain and blood work to rule reversible causes of dementia.
- **Home Visit:** Sometimes a home visit is necessary to evaluate a person in familiar surroundings to complete the overall assessment.
- **Multidisciplinary Conference:** Before a diagnosis is made, the team reviews its findings, develops an individualized treatment plan, and determines its recommendations.
- **Family Conference:** The diagnosis and recommendations are explained to the patient and family.

The AMC is affiliated with the University of California, San Francisco School of Medicine (UCSF). UCSF is a teaching, research and healthcare institution. Residents, interns, medical students, students of ancillary healthcare professions, post-graduate fellows and other trainees may observe, examine, and participate at the request and under the supervision of the attending physician in the patient's care, as part of UCSF's medical education programs.

*****In consideration of those who are sensitive to environmental odors created by chemicals and perfumes, please do not use fragrances when visiting this office.*****

Financial and Billing Policies

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments, co-insurances, deductibles and other provisions. If you have any questions, call your health plan's member services department-their number is listed in your benefit plan booklet or on your ID card.

- **Bring Your Health Information:** This includes CA ID/drivers lisence, all insurance cards, and authorization/referral forms. We will ask that you sign forms such as a release of medical information, patient information sheet, notice of disclosure, and possibly additional forms depending on your visit.
- **Co-Payments, Deductibles and Co-Insurance:** Co-pay's are due at time of your office visit. Under the terms of our contract with the various insurance plans we cannot waive any co-payments, deductibles, or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience we accept checks (payable to: UC REGENTS), debit, VISA and MasterCard. For the safety of staff and patients **WE CANNOT ACCEPT CASH**.
- **Patient Responsibility Balances:** All patient responsible balances must be paid in full or a financial arrangement made at the time of your visit.
- **Deposits:** For certain procedures, or when paying out of pocket, you may be required to pay a deposit or pay for the service in full prior to treatment.
- **Prior Authorization:** Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, or is not a covered service, you will be asked to pay prior to the time of service.
- **HMO/Managed Care Plans:** It is your responsibility to make sure a current referral has been obtained for your care with our providers. If a referral has not been obtained, the AMC will not be able to schedule any appointments until such referral is obtained. We realize this in an inconvenience, but without the referral our physicians will not be reimbursed for the services provided.
- **Medicare/Medicaid or Other Groups Insurance Policies:** I agree to pay the AMC, and AMC physicians associated with the AMC evaluation, the balance due of all charges not paid for by Medicare, Medicaid, or other group insurance plans (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees.
- **Multidisciplinary Team Meeting (MDT):** The $200 dollar out-of-pocket charge is for the multidisciplinary team meeting of staff involved with the evaluation to assess all the information gathered. This charge is not covered by Medicare, Medicaid, or any other group insurance plans.
- **Inform the AMC of Changes:** If you are a current patient, please inform the AMC if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and result in your having to pay for the cost of the entire visit.

University of California
San Francisco

UCSF

Fresno Medical Education Program

Patient Name: _____ DOB: _____

- **No Show/ Appointment Cancellation Policy:** We would like to provide you with outstanding service. This, however, requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give this appointment to another patient.
- If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a "NO SHOW". We charge a $35.00 fee for "NO SHOWS" which is not covered by any insurance plans.

I have read, understand and agree to the above NO SHOW/appointment cancellation policy and fully agree to each of the statements and agreements herein, by signing below as my free and voluntary act.

_____ _____

Patient Signature or POA Representative Date

University of California
San Francisco
UCSF
Fresno Medical Education Program

UCSF Alzheimer & Memory Center (AMC)

Personal Representative

In the space below, if so desired, please indicate any personal representative (an individual who is permitted to receive or know information concerning your healthcare for the period of 12 months from the date you sign this form). If your designated personal representative changes during the time, this form is in effect, you must contact the AMC in writing to request the changes.

Name(s) of personal representative:

1. _____ Relationship to you: _____

   Phone number: _____

A personal representative as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) is any family member, friend, or individual designated by the patient to whom the patient's health information may disclosed.

Patients Name: _____ DOB: _____

_____ _____

Patients Signature Date

University of California
San Francisco
UCSF
Fresno Medical Education Program

Alzheimer & Memory Center

AUTHORIZATION TO RELEASE/EXCHANGE PATIENT RECORDS

(A copy or facsimile of this form is as valid as the original)

TO:_____

(Doctor or Institution)

NAME OF PATIENT:_____

SSN:_____DOB:_____

NOTICE: UCSF and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. **YOUR RIGHTS:** This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) create health information to provide to a third party.

Authorization includes the release of **all** records with documentation of treatment and/or follow-up care pertaining to mental health and other information as specified below:

- ☐ Brief summary of medical history including medications
- ☐ Reports of EKG, CXR, EEG, and lab work done in the last year
- ☐ Neuropsychological Assessment
- ☐ Neurological Assessment
- ☐ Brief summary of psychiatric history including medications
- ☐ MRI or CT Scan (Please send films and report of BRAIN MRI/CT scan only)

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked**, this Authorization will expire 5 Years** after the date of my signing this form.

This Authorization may be revoked at any time. The revocation must be in writing, signed by me or my representative, and delivered to: UCSF Fresno Alzheimer & Memory Center (AMC), 2335 E Kashian Ln, #301 Fresno, CA 93701 The revocation will take effect when UCSF Fresno AMC receives it, except to the extent UCSF AMC or others have already relied on it.

I hereby authorize the UCSF Fresno Alzheimer & Memory Center to exchange information with any agency, professional or person that is deemed necessary. **I am entitled to receive a copy of this Authorization**.

_____ Print Name

_____ Signature (Patient, or individual with assigned Power of Attorney or Conservatorship)

_____ Date

_____ Witness (if patient is unable to sign) or interpreter

HEALTH INFORMATION

Please list Health Care Providers (Medical Doctors, Psychiatrists, Psychologists, Therapists, Hospitals, and Facilities) utilized over the past 5 years.

1. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

2. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

3. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

4. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

5. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

6. Name:_____ Specialty: _____

   Address:_____City_____State_____Zip_____

   Phone: _____

   Reason for Care_____

University of California
San Francisco

UCSF

School of Medicine
Fresno Medical Education Program

University of California, San Francisco, Fresno
Photography & Audio/Video Recording Consent Form

UCSF Fresno Center for Medical Education and Research
155 North Fresno Street, Fresno, CA 93701

Authorization and Consent to Photograph, Publish and Release Information

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Date: _____

Print Name: _____ Signature: _____

If subject/patient is under the age of 18, parent or legal guardian authorization is required below

Print Name: _____ Signature: _____

ADDRESS: _____

City/State/Zip _____ Telephone: (_____) _____

Witness (if unable to sign):

Print Name: _____ Signature: _____

University of California
San Francisco

UCSF

Fresno Medical Education Program

DRIVING DURING THE EVALUATION

Alzheimer & Memory Center

2335 E Kashian Ln, #301
Fresno, CA 93701

Tel: 559-227-4810
Fax: 559-227-4167

Loren I. Alving, M.D.
Director
Neurologist

Alex C. Sherriffs, M.D., ABFM
Co-Director
Family Practice

Dzung Trinh, M.D., FACP
Geriatrics

Beverly Chang, M.D.
Psychiatry

Toni Onkka, LCSW
Social Worker

Andres Sviercovich, MSW
Social Worker

Benicia Goka, M.D.
Neuroscientist

Anna Salazar
Administrative Assistant
Patient Relations

Email:
alz@fresno.ucsf.edu

Website:
www.fresno.ucsf.edu/alzheimer

Due to difficulties that patients with dementia may have driving, we ask that once our evaluation is started, **patients refrain from driving during the course of this evaluation until the family conference has concluded**. Our evaluations can help us to determine if patients are at increased risk when driving; at the family conference, we will present our recommendations on driving.

Also, please note that if we make a diagnosis of dementia, we are required by law to send a report stating such to your local Department of Motor Vehicles.

By signing, I acknowledge that I have read the above.

_____

Signature of Patient
(or individual with assigned Power of Attorney or Conservatorship)

_____

Signature of Careprovider

_____

Relationship to Patient

Date: _____

University of California
San Francisco

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Fresno Medical Education Program

Alzheimer & Memory Center
Patient Information

(To be filled out by the patient or patient representative)

Patient Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (Apt.#) (City) (State) (Zip Code)

Telephone Number: Home ( ) _____ Cell/Work: ( ) _____

Date of Birth: _____ Social Security #: _____ Please circle: Male Female

1. Primary Insurance Name: _____
   Address: _____ City: _____ State: _____ Zip Code: _____
   Name of Policy Holder: _____
   Policy Holder SS#: _____ Policy Holder DOB: _____
   Relationship to Patient: _____
   Insurance ID: _____ Group #: _____ Effective Date: _____

2. Secondary Insurance Name: _____
   Address: _____ City: _____ State: _____ Zip Code: _____
   Name of Policy Holder: _____
   Policy Holder SS#: _____ Policy Holder DOB: _____
   Relationship to Patient: _____
   Insurance ID: _____ Group #: _____ Effective Date: _____

Guarantor Name: _____ _____
Last First Middle Relationship to Patient

Address: _____

Telephone Number: Home ( ) _____ Cell/Work: ( ) _____

Please sign below to acknowledge the following statement:

I request that payment of authorized Medicare or medical benefits to which I am entitled be made either to me or on my behalf to the Alzheimer & Memory Center (AMC) for any services furnished me by the AMC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. If I am unable to sign this form, my representative may sign on my behalf. In Medi-care assigned cases, the AMC agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

********I understand that I am financially responsible for all charges whether or not paid by insurance********

Signature: _____ by _____ Date: _____
(Patient) (Representative signature)

_____ _____
Representative's relationship to patient Representative's address (street) (city) (state) (zip)

University of California
San Francisco

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Fresno Medical Education Program

NOTICE OF DISCLOSURE

DATE: _____

Alzheimer & Memory Center
2335 E Kashian Ln, #301
Fresno, CA 93701
Tel: 559-227-4810
Fax: 559-227-4167

I, _____ of _____
(NAME) (STREET) (CITY) (ZIP)

understand that the $200.00 fee for the Multi-Disciplinary Team Meeting associated with the evaluation of _____ at the UCSF
(NAME OF PATIENT)

Fresno Alzheimer & Memory Center is not a covered service by my insurance company and is my responsibility to pay.

_____ _____
Signature of Guarantor Date

Email:
alz@fresno.ucsf.edu

Website:
www.fresno.ucsf.edu/alzheimer

FORM A Date: _____

UCSF FRESNO ALZHEIMER & MEMORY CENTER

Patient's Name:_____ Birth date: _____ Age: _____

Name of Person Completing Form: _____ Relationship to Patient: _____

******** Please list all medications, vitamins and herbs that the patient is taking. ********

	NAME	DOSE	FREQUENCY
	Example: *Wxyzmed*	*325 mg*	*twice a day, as needed*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

**Allergies to Medications: _____

Preferred Pharmacy: _____
Name Address City Zip Code Telephone

CURRENT FUNCTION

What symptoms are CURRENTLY occurring? *If YES, please give examples.*

Yes	No	
☐	☐	Memory loss for recent events_____
☐	☐	Memory loss for remote events_____
☐	☐	Gets lost _____
☐	☐	Wandering _____
☐	☐	Change in eating habits_____
☐	☐	Eats more_____
☐	☐	Eats less,or eats more sweets_____
☐	☐	Change in sleeping habits _____
☐	☐	Depression_____
☐	☐	Aggressiveness_____
☐	☐	Physical_____
☐	☐	Verbal_____
☐	☐	Hallucinations (when, how often)_____
☐	☐	Paranoia/Suspiciousness_____
☐	☐	Hides things_____
☐	☐	Decline in social activity_____
☐	☐	Loss of interest in previous hobbies_____
☐	☐	Decreased awareness in current events_____
☐	☐	Problem recognizing familiar persons? Who? _____

HISTORY OF MEMORY/BEHAVIORAL CHANGES

What were the first changes noted?

☐ Memory problems: Year _____
☐ Getting lost: Year _____
☐ Depression: Year _____
☐ Paranoia: Year _____
☐ Other _____: Year _____
☐ Language problems: Year _____
☐ Behavior/personality change: Year _____
☐ Hallucinations: Year _____
☐ Suspiciousness: Year _____

When did the changes first occur? _____

Was the progression: ○ Slow ○ Rapid
Was the onset: ○ Gradual ○ Sudden

List behavior changes and dates (in chronological order), such as changes at family/holiday gatherings, changes in driving, housekeeping, social activities, etc.

Date	**Description of behavioral changes**	***Examples below:***
Nov. 1990	Problems making Thanksgiving dinner, which she had always prepared well in past.	
Jun. 1991	Began forgetting names of grandchildren.	
Jan. 1995	Got lost while driving to familiar grocery store.	
1997	Began accusing others of stealing her money/personal items.	

HEALTH INFORMATION

Indicate which of the following illnesses the patient has currently or has had in the past.

General
- ☐ Appetite loss
- ☐ Weight loss

Heart
- ☐ High cholesterol
- ☐ Congestive heart failure
- ☐ Irregular heart beat
- ☐ High blood pressure
- ☐ Has had heart attack
- ☐ By-pass surgery (year: ___)
- ☐ Pacemaker (year: ____)

Eyes/Ears/Nose
- ☐ Glaucoma
- ☐ Visual Impairment
- ☐ Hearing impairment
- ☐ Aides:
- ☐ Allergies

Abdominal
- ☐ Ulcers
- ☐ Abdominal pain

Lungs
- ☐ Asthma
- ☐ Emphysema

Cancer Type _____
Year diagnosed _____
Treatment: ☐ radiation ☐ chemo ☐ other

Endocrine
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ B12 deficiency
- ☐ Hysterectomy

Skin
- ☐ Bed Sores
- ☐ Skin infections

Head & Neck
- ☐ Difficulty speaking
- ☐ Difficulty swallowing

Bones & Joints
- ☐ Arthritis
- ☐ Hip/leg fractures
- ☐ Tuberculosis

Blood
- ☐ Anemia
- ☐ Leukemia

Brain
- ☐ Alzheimer's disease
- ☐ Epilepsy/seizures
- ☐ Parkinson's disease
- ☐ Headaches
- ☐ Stroke year_____
- ☐ TIA year_____
- ☐ Head trauma
  - ☐ with loss of consciousness
  - ☐ without loss of consciousness
  - ☐ not sure

Infections
- ☐ Syphilis, history of
- ☐ Chronic bladder infection

Kidney/Bladder
- ☐ Incontinence
- ☐ Kidney Disease

Mental Health
- ☐ Anxiety
- ☐ Depression: date _____
- ☐ treatment ☐ hospitalizatior
- ☐ Counseling
- ☐ Schizophrenia

OTHER MEDICAL PROBLEMS:

GENERAL INFORMATION

Place of birth: _____Raised where? _____ One of _____ children.
(If born out of California, age when moved to California? ____)

Please mark highest level of education completed:
☐Professional/Doctoral degree (in _____)
☐Masters degree (in _____)
☐Bachelors degree (in _____)
☐A.A./Vocational/Technical degree (in _____)
☐High school graduate/GED
If less than high school degree/GED, what grade completed? ____

Primary occupation/employment of the patient throughout life? _____

Primary occupation/employment of the patient's spouse throughout life?_____

Patient's current relationship status:
☐Married: ☐Never married ☐Widowed ☐Divorced ☐Separated ☐Domestic partner

If ever married How many times? __ At what age(s) _____ How long? _____
Number of children (indicate from which partner) _____/_____/_____
partner #1 partner#2 partner#3

Does the patient have a valid driver's license? ☐Yes ☐No (if yes incense #: _____ exp:_____)
Is the patient still driving? ☐Yes ☐ No Any recent accidents? ☐Yes ☐ No
Date of last accident: _____ Was he/she at fault? ☐Yes ☐ No

*******California law requires that we make a report to the Health Department if we make a diagnosis of dementia. This may result in loss of driving privileges or a request that the patient take a driver's test. We ask that all patient's refrain from driving during the evaluation.**

Does the patient smoke? ☐Yes ☐No (since what age: ___) How much: _____
☐Used to (how long: _____, how much: _____)

Does patient drink alcohol? ☐Yes ☐No (since what age ___) How much: _____
☐Used to (how long: _____, how much: _____)

Was there ever a period when the patient drank a lot (i.e., 4 or more drinks at a time)?
☐Yes ☐No: Age when he/she began drinking this amount_____
number of years this drinking pattern lasted _____

Does the patient have or has the patient had a drug abuse problem (other than alcohol), including prescription drugs? ☐Yes ☐No
If YES, what was the drug of choice? _____
Age when he/she started to abuse drugs _____
Age when he/she quit abusing drugs _____

SOCIAL HISTORY

What was the patient's personality **before** his/her present difficulties?

_____

_____

_____

_____

_____

_____

SAFETY Due to concerns related to judgment in persons with dementia, we are asking if there Any guns or other weapons in the home.

☐Yes ☐No if yes, does the patient have access to the weapons? ☐Yes ☐No

FAMILY MEDICAL HISTORY

Have any of the following conditions or diseases occurred in the **patient's primary relatives**? If **yes**, please list the relative's relationship to the patient. Primary relatives include the patient's **parents**, **brothers and sisters,** and **children**.

Disease/Condition	Primary relative(s)
☐ Dementia or dementia like symptoms	_____
☐ Alzheimer's disease	_____
☐ Parkinson's disease	_____
☐ Down Syndrome	_____
☐ Stroke	_____
☐ Heart Disease	_____
☐ Primary psychosis (e.g. delusions, schizophrenia)	_____
☐ Primary affective/mood disorder (e.g. depression, mania)	_____
☐ Alcohol-related disorder (e.g. abuse, dependence)	_____
☐ Major psychiatric disturbance	_____

Other diseases that run in the patient's family:

_____

_____

_____

For questions 1- 7, choose the category that best describes the patient in your opinion.
1 = patient is unable to do the activity described
.5 = patient has some trouble with the task
0 = patient can do the task normally

		Unable	Some Trouble	Normal
1.	Ability to find way around familiar streets	☐ 1	☐ .5	☐ 0
2.	Perform household tasks	☐ 1	☐ .5	☐ 0
3.	Cope with small sums of money	☐ 1	☐ .5	☐ 0
4.	Remember short list of items	☐ 1	☐ .5	☐ 0
5.	Find way around indoors	☐ 1	☐ .5	☐ 0
6.	Interpret surroundings (e.g., recognize whether in a hospital or at home, discriminate between ' patients, doctors, nurses, relatives, etc.)	☐ 1	☐ .5	☐ 0
7.	Recall recent events (e.g. recent outings, visits by relatives)	☐ 1	☐ .5	☐ 0

For question 8, choose best answer.

		Yes	More than Usual	No
8.	Tendency to dwell in the past	☐ 1	☐ .5	☐ 0

HABITS
Choose the best description for each:

Eating:
- ☐ Cleanly with proper utensils — 0
- ☐ Messily with spoon only — 1
- ☐ Eats only simple solids (e.g., biscuits) — 2
- ☐ Has to be fed — 3

Dressing:
- ☐ Unaided — 0
- ☐ Occasionally misplaced buttons — 1
- ☐ Commonly forgets items, wrong sequence — 2
- ☐ Unable to dress — 3

Bladder and bowel control:
- ☐ Complete sphincter control — 0
- ☐ Occasional wet beds — 1
- ☐ Frequent wet beds — 2
- ☐ Unable to control urine and stool — 3

[For office use only. Total: _____]

Please type in ONE letter under each category that best describes the patient in your opinion.

1. **MEMORY**
   a. No memory loss or slight inconsistent forgetfulness
   b. Consistent slight forgetfulness; partial recollection of events; "benign" forgetfulness
   c. Moderate memory loss; more marked for recent events; deficiency interferes with everyday activities
   d. Severe memory loss; only highly learned material retained; new material rapidly lost
   e. Severe memory loss; only fragments remain

2. **ORIENTATION**
   a. Fully oriented
   b. Fully oriented except for slight difficulty with time relationships
   c. Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere
   d. Severe difficulty with time relationships; usually disoriented in time, often to place
   e. Oriented to person only

3. **JUDGEMENT AND PROBLEM SOLVING**
   a. Solves everyday problems well; judgement good in relation to past performance
   b. Slight impairment in solving problems, similarities, differences
   c. Moderate difficulty in handling problems, similarities, differences; social judgement usually maintained
   d. Severely impaired in handling problems, similarities, differences; social judgement usually impaired
   e. Unable to make judgements or solve problems

4. **COMMUNITY AFFAIRS**
   a. Independent function at usual level in job, shopping, business and financial affairs, volunteer and social groups
   b. Slight impairment in these activities
   c. Unable to function independently at these activities though may still be engaged in some; appears normal to casual inspection
   d. No pretense of independent function outside home; appears well enough to be taken to functions outside a family home
   e. No pretense of independent function outside of home; appears too ill to be taken to functions outside a family home

5. **HOME AND HOBBIES**
   a. Life at home, hobbies, intellectual interests well maintained
   b. Life at home, hobbies, intellectual interests slightly impaired
   c. Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned
   d. Only simple chores preserved; very restricted interests, poorly sustained
   e. No significant function in home

6. **PERSONAL CARE**
   a. Fully capable of self-care
   b. Needs prompting
   c. Requires assistance in dressing, hygiene, keeping of personal effects
   d. Requires much help with personal care, frequent incontinence.

FORM B

UCSF FRESNO ALZHEIMER & MEMORY CENTER

Patient's Name:_____ Birth date: _____ Date: _____

Name of Person Completing Form: _____ Relationship to Patient: _____

****Please answer the following questions about yourself:***

1) What is your relationship to the patient?

1. Wife/husband/significant other
2. Son
3. Daughter
4. Son-in-law
5. Daughter-in-law
6. Other family member
7. Friend
8. Other

2) How often do you see him or her?

1. Everyday
2. 4-6 days per week
3. 2-3 days per week
4. Once a week
5. Once every two weeks
6. Once per month
7. Less than once per month

3) On average, how many hours per week do you spend with him or her? _____
[Note: 1 week = 168 hours.]

4) How many years have you known the patient? ____ years

5) What is your gender? ☐ Male ☐ Female

6) How old are you? ____ years

LIVING ARRANGEMENT:

Who lives with the patient? _____
If patient lives alone, how far do you live from him/her? _____

Who is the primary caregiver (the person who mostly gives or oversees care)?

_____

_____

Who is/are the secondary informal caregiver(s), those who help out in emergencies or provide respite for the primary caregiver?

_____

_____

Please list members of the patient's family and/or friends who would be able to provide more information regarding the patient's health and behavior in the past and present.

NAME	Relationship and Age	Location/Tel. #
1.		
2.		
3.		
4.		

CURRENT PATIENT NEEDS:

Is the patient's current living situation adequate? ☐Yes ☐No
If **NO**, then what options have been considered and how seriously have these been pursued?

_____

_____

Do you have current concerns or anticipate problems for the patient in the following areas: food/nutrition, patient's self-care, physical health, medication management, emotional factors, household tasks, socializing/hobbies, financial matters, and/or transportation?
☐Yes ☐No If **YES**, please explain:

_____

_____

_____

_____

_____

Legal arrangements completed by the patient ☐Yes ☐No

☐Yes ☐No Has a will or living trust.

☐Yes ☐No Has an Advanced Health Care Directive *or* Durable Power of Attorney for Health Care.

Who is the decision-maker?_____

☐Yes ☐No Has a General Power of Attorney for finances.

Who is the decision-maker?_____

☐Yes ☐No Had legal advice concerning personal finances.

☐Yes ☐No Arranged for care when no longer able to care for self.

CURRENT CAREGIVER NEEDS:

Is your current living situation adequate? ☐Yes ☐No
Do you require resources for alternative living situation? ☐Yes ☐No

Please describe caregiver and/or family **stress caused by patient's illness**, or interference with family member's work or other activities:

_____

_____

_____

_____

_____

_____

In what ways has the caregiver/family personally **adapted their lifestyle** to accommodate behavior changes of the patient?

_____

_____

_____

_____

_____

Do you have current concerns or anticipate problems for yourself/the primary caregiver in the following areas:

Food/nutrition ☐Yes ☐No *if yes, please explain:*

_____

_____

_____

Physical health ☐Yes ☐No *if yes, please explain:*

_____

_____

_____

Financial matters ☐Yes ☐No *if yes, please explain:*

_____

_____

_____

Emotional factors ☐Yes ☐No *if yes, please explain:*

_____

_____

_____

Socializing/hobbies? ☐Yes ☐No *if yes, please explain:*

_____

_____

_____

**As part of our role as one of the state Alzheimer's Research Centers of California, we have been asked to collect the following information:

What is the patient's race?
☐White ☐Other Race: _____
Is the patient Spanish/Hispanic/Latino? ☐No ☐Yes (If **YES**, choose one):
☐North American (Mexican, Mexican-American, Chicano ☐Puerto Rican ☐Cuban
☐South American ☐Central American ☐Haitian ☐Other:

☐American Indian: (including North, South and Central American Indian) or Alaska Native (including Aleut and Eskimo)

☐Asian (choose one): ☐Asian Indian ☐Cambodian ☐Chinese ☐Filipino
☐Japanese ☐Hmong ☐Korean ☐Laotian ☐Vietnamese ☐Other:

☐Black, African American
☐Pacific Islander (choose one): ☐Native Hawaiian ☐Guamanian ☐Samoan
Other Pacific Islander: _____

What is the patient's sexual orientation?
☐ Prefer not to answer
☐ Heterosexual or straight
☐ Gay or Lesbian
☐Transgender
☐ Bisexual
☐ Don't Know

Directions: Please rate the patient's ability to perform certain everyday tasks NOW, as compared to his/her ability to do these same tasks 10 years ago. In other words, try to remember how he/she was doing 10 years ago and indicate any change you have seen. Rate the amount of change on a five-point scale ranging from: 1) no change or actually performs better than 10 years ago, 2) occasionally performs the task worse but not all of the time, 3) consistently performs the task a little worse than 10 years ago, 4) performs the task much worse than 10 years ago, or 5) don't know. Circle the number that fits your response.	Better or no change	Questionable occasionally worse	Consistently a little worse	Consistently much worse	Don't know
Compared to 10 years ago, has there been any change in.....Memory					
1. Remembering a few shopping items without a list.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Remembering things that happened recently (such as recent outings, events in the news).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Recalling conversations a few days later.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Remembering where she/he has placed objects.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Repeating stories and/or questions.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Remembering the current date or day of the week.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Remembering he/she has already told someone something.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Remembering appointments, meetings, or engagements.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Compared to 10 years ago, has there been any change in.....Language					
1. Forgetting the names of objects.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Verbally giving instructions to others.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Finding the right words to use in a conversation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Communicating thoughts in a conversation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Following a story in a book or on TV.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Understanding the point of what other people are trying to say.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Remembering the meaning of common words.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Describing a program he/she has watched on TV.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. Understanding spoken directions or instructions.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Compared to 10 years ago, has there been any change in..... Visual-Spatial and Perceptual Abilities					
1. Following a map to find a new location.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Reading a map and helping with directions when someone else is driving.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Finding one's car in a parking lot.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Finding the way back to a meeting spot in the mall or other location.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Finding his/her way around a familiar neighborhood.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Finding his/her way around a familiar store.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Finding his/her way around a house visited many times.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Compared to 10 years ago, has there been any change in.....Executive Functioning: Planning					
1. Planning the sequence of stops on a shopping trip.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
2. The ability to anticipate weather changes and plan accordingly (ie. bring a coat or umbrella).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
3. Developing a schedule in advance of anticipated events.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
4. Thinking things through before acting.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
5. Thinking ahead.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
Compared to 10 years ago, has there been any change in.....Executive Functioning: Organization					
1. Keeping living and work space organized.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
2. Balancing the checkbook without error.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
3. Keeping financial records organized.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
4. Prioritizing tasks by importance.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
5. Keeping mail and papers organized.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
6. Using an organized strategy to manage a medication schedule involving multiple medications.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
Compared to 10 years ago, has there been any change in.....Executive Functioning: Divided Attention					
1. The ability to do two things at once.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
2. Returning to a task after being interrupted.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
3. The ability to concentrate on a task without being distracted by external things in the environment.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9
4. Cooking or working and talking at the same time.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 9

Please answer the following questions based on changes that have occurred since he/she first began to experience memory problems.

Mark "Yes" only if the symptom(s) has been present in the last month. Otherwise, mark "No".

For each item marked "Yes":
Rate the **SEVERITY** of the symptom (**how it affects the patient**):
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)

For each item marked "Yes":
Rate the **DISTRESS** you experience due to that symptom (**how it affects you**):
0 = **Not distressing at all**
1 = **Minimal** (slightly distressing, not a problem to cope with)
2 = **Mild** (not very distressing, not always 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 with)

---

1. Delusions — Does the patient believe that others are stealing from him/her or planning to harm him/her in some way? ☐YES ☐NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

2. Hallucinations — Does the patient act as if he/she hears voices? Does he/she talk to people who are not there? ☐YES ☐NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

3. Agitation/Aggression — Is the patient stubborn and resistive to help from others? ☐YES ☐NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

4. Depression/Dysphoria — Does the patient act as if he/she is sad or in low spirits? Does he/she cry? ☐YES ☐NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

5. Anxiety

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?

☐ YES ☐ NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

6. Elation/Euphoria

Does the patient appear to feel too good or act excessively happy?

☐ YES ☐ NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

7. Apathy/Indifference

Does the patient seem less interested in his/her usual activities and in activities and plans of others?

☐ YES ☐ NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

8. 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?

☐ YES ☐ NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

9. Irritability/Lability

Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?

☐ YES ☐ NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

10. Motor Disturbance

Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?

☐ YES ☐ NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

11. Nighttime Behaviors

Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?

☐ YES ☐ NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

---

12. Appetite/Eating

Has the patient lost or gained weight, or had a change in the type of food he/she likes?

☐ YES ☐ NO

If **YES**: SEVERITY: 1 2 3 DISTRESS: 0 1 2 3 4 5

Circle the category that best describes the patient in your opinion.
Ratings should be based on symptoms occurring over the past week.

0 = not present 1 = mild or occasional 2 = severe
Do not circle if symptoms are longstanding or chronic.

MOOD RELATED SIGNS			
1. ANXIETY - anxious expression, worrying more than usual	☐0	1☐	2☐
2. SADNESS - sad expression, sad voice, tearfulness	☐0	1☐	2☐
3. LACK OF REACTION - to pleasant events	☐0	1☐	2☐
4. IRRITABILITY - easily annoyed, more short tempered than usual	☐0	1☐	2☐
BEHAVIORAL DISTURBANCES			
5. AGITATION - restlessness, increased pacing, handwringing	☐0	1☐	2☐
6. RETARDATION - slow movements, slow reactions, slow speech	☐0	1☐	2☐
7. MULTIPLE PHYSICAL COMPLAINTS - (score 0 if gastrointestinal symptoms only)	☐0	1☐	2☐
8. LOSS OF INTEREST - less involved in usual activities (score only if changed in last 2-3 weeks)	☐0	1☐	2☐
PHYSICAL SYMPTOMS			
9. APPETITE LOSS - eating less than usual	☐0	1☐	2☐
10. WEIGHT LOSS - (score 2 if more than 5 lbs in past month)	☐0	1☐	2☐
11. LACK OF ENERGY fatigues easily, unable to sustain activities (score only if change occurred in past month)	☐0	1☐	2☐
CYCLIC FUNCTIONS			
12. DIURNAL VARIATION IN MOOD - symptoms worse in the morning	☐0	1☐	2☐
13. DIFFICULTY FALLING ASLEEP - later than usual for this person	☐0	1☐	2☐
14. MULTIPLE AWAKENINGS DURING SLEEP	☐0	1☐	2☐
15. EARLY MORNING AWAKENING - earlier than usual for this person	☐0	1☐	2☐
IDEATIONAL DISTURBANCES			
16. SUICIDE - feels life is not worth living, has suicidal wishes, or makes suicide attempt	☐0	1☐	2☐
17. SELF-DEPRECIATION - self-blame, feelings of failure	☐0	1☐	2☐
18. PESSIMISM - anticipation of the worst	☐0	1☐	2☐
19. MOOD CONGRUENT DELUSIONS - delusions of poverty, illness or loss	☐0	1☐	2☐

Total Score_____

Indicate the services that the patient and the primary caregiver received in the past three months.

	TYPE OF SERVICE	RECIPIENT OF SERVICE			
		PATIENT		CAREGIVER	
		Yes	No	Yes	No
a.	Counseling (individual or group format)	☐	☐	☐	☐
b.	Family/martial counseling-education	☐	☐	☐	☐
c.	Community support group (where)? _____	☐	☐	☐	☐
d.	Primary care of other physician services	☐	☐	☐	☐
e.	Other health practitioners (dental, PT, OT)	☐	☐	☐	☐
f.	Case management services	☐	☐	☐	☐
g.	Transportation services (non-emergency)	☐	☐	☐	☐
h.	Emergency transportation services	☐	☐	☐	☐
i.	Congregate meals (senior center)	☐	☐	☐	☐
j.	Home delivered meals (meals-on-wheels)	☐	☐	☐	☐
k.	Home health care services (who)? _____	☐	☐	☐	☐
l.	Homemaker/chore services	☐	☐	☐	☐
m.	Adult day care	☐	☐	☐	☐
n.	Alzheimer Day Care Resource Centers	☐	☐	☐	☐
o.	Caregiver Resource Centers	☐	☐	☐	☐
q.	Nursing home	☐	☐	☐	☐
r.	Assisted living (name) (s): _____	☐	☐	☐	☐
s.	In-patient hospital services	☐	☐	☐	☐
t.	Adult protective services	☐	☐	☐	☐
u.	Other services (specify)	☐	☐	☐	☐

Patient Name:_____ Date:_____
Patient ID #_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	Independence (1 Point)	Dependence (0 Points)
	NO supervision, direction or personal assistance.	WITH supervision, direction, personal assistance or total care.
BATHING Points: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	(1 POINT). Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.
TOTAL POINTS: _____	SCORING: 6 = High (*patient independent*) 0 = Low (*patient very dependent*	

Source:
try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

See Reverse

MaineHealth

Functional Activities Questionnaire

In the past 4 weeks, did the patient have any difficulty or need help with:	Not applicable	Normal	Has difficulty, but does by self	Requires assistance	Dependent
1. Writing checks, paying bills, or keeping financial records	○	○	○	○	○
2. Assembling tax records, business affairs, or papers	○	○	○	○	○
3. Shopping alone for clothes, household necessities, or groceries	○	○	○	○	○
4. Playing a game of skill or working on a hobby	○	○	○	○	○
5. Heating water, making a cup of coffee, or turning off the stove	○	○	○	○	○
6. Preparing a balanced meal	○	○	○	○	○
7. Keeping track of current events	○	○	○	○	○
8. Paying attention to, understanding, or discussing a TV program, book, or magazine	○	○	○	○	○
9. Remembering appointments, family occasions, holidays, or medications	○	○	○	○	○
10. Traveling out of the neighborhood, driving, or arranging to take busses	○	○	○	○	○

Adapted from: Pfeffer RI, Kurosaki TT, Harrah CH, Chance JM, Filos S. Measurement of functional activities in older adults in the community. *J Gerontol.* 1982 May;37(3):323-329 by permission of the Gerontological Society of America.

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Caregiver Self-Assessment Questionnaire

How are you?

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own wellbeing. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

During the past week or so, I have...

1. Had trouble keeping my mind on what I was doing ..... ☐Yes ☐No
2. Felt that I couldn't leave my relative alone ..... ☐Yes ☐No
3. Had difficulty making decisions ..... ☐Yes ☐No
4. Felt completely overwhelmed ..... ☐Yes ☐No
5. Felt useful and needed ..... ☐Yes ☐No
6. Felt lonely ..... ☐Yes ☐No
7. Been upset that my relative has changed so much from his/her former self ..... ☐Yes ☐No
8. Felt a loss of privacy and/or personal time ..... ☐Yes ☐No
9. Been edgy or irritable ..... ☐Yes ☐No
10. Had sleep disturbed because of caring for my relative ..... ☐Yes ☐No
11. Had a crying spell(s) ..... ☐Yes ☐No
12. Felt strained between work and family responsibilities ..... ☐Yes ☐No
13. Had back pain ..... ☐Yes ☐No
14. Felt ill *(headaches, stomach problems or common cold)* ..... ☐Yes ☐No
15. Been satisfied with the support my family has given me ..... ☐Yes ☐No
16. Found my relative's living situation to be inconvenient or a barrier to care ..... ☐Yes ☐No
17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. _____
18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. _____

Comments:
(Please feel free to comment or provide feedback)

_____

_____

_____

_____

_____

_____

_____

_____

Self-evaluation:

To Determine the Score:

1. Reverse score questions 5 and 15. *(For example, a "No" response should be counted as "Yes" and a "Yes" response should be counted as "No")*
2. Total the number of "yes" responses.

To Interpret the Score:

Chances are that you are experiencing a high degree of distress:

- If you answered "Yes" to either or both Questions 4 and 11; or
- If your total "Yes" score = 10 or more; or
- If your score on Question 17 is 6 or higher; or
- If your score on Question 18 is 6 or higher.

Next steps:

- Consider seeing a doctor for a check-up for yourself.
- Consider having some relief from caregiving. (Discuss with the doctor or a social worker the resources available in your community.)
- Consider joining a support group

Valuable Resources for Caregivers:

Eldercare Locator:
(a national directory of community services)
1-800- 677-1116
www.aoa.gov/elderpage/locator.html

Family Caregiver Alliance
1-415- 434-3388
www.caregiver.org

Medicaid Hotline
Baltimore, MD
1-800-638-6833

National Alliance for Caregiving
1-301-718-8444
www.caregiving.org

National Family Caregivers Association
1-800 896-3650
www.nfcacares.org

National Information Center for Children and Youth with Disabilities
1-800-695-0285
www.nichcy.org

Local Resources and Contacts:

SOCIAL AND BEHAVIORAL FOLLOW-UP INFORMATION

Name: _____ AGE: _____

Does the patient have any of these symptoms? Are they problematic when thinking about caring for them? Explain/describe if necessary.

Agitation/Anxiety: _____
Halluciations: _____
Wandering: _____

Safety Concern

1. **Do you have any safety concerns for your loved one with dementia?** ☐ Yes ☐ No

   Please list your concerns:

   _____

2. **Has the patient had two or more falls in the past year?** ☐ Yes ☐ No
3. **Has the patient had any fall with injury in the past year?** ☐ Yes ☐ No

Alcohol Consumption

1. **How often does the patient have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol does the patient have on a typical day?**
   - ☐ None
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often does the patient have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily