Providence HEALTH CARE

Eldercare Clinic
Dementia Caregiver Resilience Clinic

SCREENING REFERRAL

Intake Information and Consent

PART 1 - TO BE COMPLETED BY THE CAREGIVER

Caregiver Name: _____ PHN: _____ DOB: _____

Telephone Number: _____ Is it okay to leave a message? ☐ Yes ☐ No

Can we contact you by email? ☐ No ☐ Yes - If yes, email address: _____

Caregiver Family Doctor / Practitioner name: _____

Person with dementia that I am a caregiver for is my ☐ Spouse ☐ Parent ☐ Sibling ☐ Other: _____

Is this person being seen in the Elder Care Clinic? ☐ No ☐ Yes, by Dr. _____

Who suggested the Dementia Caregiver Resilience Clinic to you?: _____

I am already connected with the Alzheimer Society of BC ☐ No ☐ Yes

CONSENT

I consent to have my family doctor/practitioner (named above) share my health history and refer me to the Dementia Caregiver Resilience Clinic Team at the St. Paul's Hospital Elder Care Clinic.

Caregiver Signature: _____ Date: _____

*** Please take this form to your family doctor / practitioner for completion ***

PART 2 - TO BE COMPLETED BY THE CAREGIVER'S FAMILY DOCTOR / PRACTITIONER

It has been identified (see above) that your patient may benefit from a referral to the Dementia Caregiver Resilience Clinic at St. Paul's Hospital.

We need your referral so that your patient may receive services that will support them in their care-giving role.

1. **Please complete the Screening Questionnaire on page 2 with your patient, the caregiver**
2. **Provide the following:**
   - **CAREGIVER'S HEALTH HISTORY** (Physical & mental health)
   - **CAREGIVER MEDICATION LIST:** ☐ Additional information attached
3. **Identify the services requested: (if known)**
   ☐ 1:1 Psychotherapy ☐ Group Psychotherapy ☐ Caregiver Skill Building ☐ Emotional Support and Resources
4. **Sign below**
   I support the referral of _____ to the St. Paul's Elder Care Dementia Caregiver Resilience Clinic (Occupational Therapist, Social Worker and Geriatric Psychiatrist)

   While I understand not all patients will be seen by psychiatry, **I will submit a no charge MSP referral to Dr. Susan More MD FRCP(c) through my office**

Family Physician/Practitioner Signature: _____ Date: _____

PLEASE FAX COMPLETED REFERRAL TO 604-806-8390 at your earliest convenience.
Attention: Dementia Caregiver Resilience Clinic

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SCREENING QUESTIONNAIRE

To be completed by Caregiver

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.

Name: _____ Date: _____

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	I feel alone in dealing with the demands of care giving.	☐ **YES**	☐ **NO**
4	When I am trying to help or support my family member with dementia, we often argue.	☐ **YES**	☐ **NO**
5	I spend more than half my day providing care to my family member.	☐ **YES**	☐ **NO**
6	I have been caring for my family member with dementia much longer than I expected to.	☐ **YES**	☐ **NO**
7	My family member will soon be, or has moved into a residential care home, and this transition is tough for me.	☐ **YES**	☐ **NO**
8	My family member has more than one dementia-related behaviour. (e.g. anxiety, apathy, verbal or physical aggression, getting lost, refusing care)	☐ **YES**	☐ **NO**
9	**Other major concerns:** _____ _____ _____ _____ _____		