

Who referred you to USF Health Alzheimer's Center? _____

If this is your physician, what is their phone number? (____) _____ - _____

Does the patient have a problem with memory? Definitely ____ Questionable ____

In what year were problems with memory first noted? _____

Has the problem gotten worse since then? Yes No
 Rapidly ____ Slowly ____ Don't Know ____

Has the patient ever been evaluated for the problem? Yes No

When: _____ Where: _____

By Whom: _____

Did he/she have a physical exam? Yes No

Results: _____

Did he/she have any laboratory tests? Yes No

Results: _____

Did he/she ever have a CAT Scan ____ or MRI Scan ____? Yes No

When: _____ Where: _____

Results: _____

Were you told that the patient **definitely** has Alzheimer's disease? Yes No

Were you told that the patient **possibly** has Alzheimer's disease? Yes No

Were you told that the patient has some other type of memory disorder? Yes No

If yes, what? _____

Is the patient still able to handle his/her checkbook? Yes No

Is the patient still able to recognize friends? Yes No

Is the patient still able to recognize family? Yes No

Is the patient still able to recognize the caregiver? Yes No

Does the patient still drive? Yes No

Is the patient still able to dress him/herself?

Alone _____

Needs some help _____

Needs total help _____

Has there been any problem with getting to the bathroom on time?

Never _____

Occasionally _____

Frequently/all the time _____

Is the patient still able to carry on a conversation?

Fully _____
 Impaired _____
 Absent _____

The patient has a history of (check all that apply):

Alcohol or drug abuse	_____	Emotional/Psychiatric problems	_____
Cancer	_____	Head injury	_____
Cardiac problems	_____	High blood pressure	_____
Diabetes	_____	Stroke	_____

What other medical problems does the patient have? Has he or she had any surgeries?

What medications and supplements is the patient taking now? List all prescribed and over-the-counter. (Continue on back or attach a separate sheet if needed.)

<u>Name</u>	<u>Dosage</u>	<u>How Often</u>	<u>Reason Taken</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the patient have any allergies to medications? If yes, please list below. Yes No

Does the patient have any non-medication allergies? If yes, please list below. Yes No

Local Pharmacy Name: _____

Address: _____

Telephone Number: (____)____-_____

Mail Order Pharmacy Name: _____

Telephone Number: (____)____-_____ ID# _____

Has anyone on the patient's side of the family had problems with memory disorders, senility, or Alzheimer's disease? Yes No

What was/is the patient's occupation? _____

What was patient's highest level of education? _____

Does the patient have any of the following problems with mood or behavior? Check all that apply)

- Impatient, cranky, irritable, or resistive to help _____
- Depression, sadness, or crying spells _____
- Abnormal happiness _____
- Sleep problems (too much or too little) _____
- Nervous or worrying _____
- Restlessness, rummaging or pacing _____
- Loss of interest in usual activities _____
- Paranoia or false beliefs _____
- Hallucinations (false visions or voices) _____
- Impulsive or embarrassing behavior _____
- Physical aggression _____
- Changes in appetite, weight, or eating habits _____

Questions for the Caregiver:

What is your goal for this evaluation?

Do you belong to a support group? Yes No

Do you have someone who can give you some relief if you need to go to the doctor, hair dresser, or out to see friends? Yes No

Who	Relationship	How Often	How Long
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What was/is your occupation? _____

Do you feel you need:

- | | | |
|--|-----|----|
| Help with making a diagnosis? | Yes | No |
| Help with managing patient's behavior? | Yes | No |
| Help with handling your own feelings? | Yes | No |

Would you like to make an appointment (for you or the patient) to see a geriatric internal medicine doctor? Yes No

Do you need more information about community resources? Yes No

Would you like information about research projects or drug studies at the USF Health Alzheimer's Center? Yes No

Insurance Information:

Please complete all applicable information. This information is necessary to verify your coverage. Some information may be on the back of your card.

Name of patient's primary insurance: _____ Yes No
 Subscriber Name: _____
 Policy number: _____ Group Number: _____
 Effective Date: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone Number: _____

Is the Primary Insurance an HMO or PPO? Yes No
 If so, does the patient need a referral to be seen by a specialist? Yes No

Name of patient's secondary insurance: _____ Yes No
 Subscriber Name: _____
 Policy number: _____ Group Number: _____
 Effective Date: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone Number: _____

Is the Secondary Insurance an HMO or PPO? Yes No
 If so, does the patient need a referral to be seen by a specialist? Yes No

Remarks: Please use this space to provide any other information you think might be helpful in evaluating the patient's memory problem.

Please complete the next section which is required by the Centers for Medicare & Medicaid Services (CMS) under the Meaningful Use Stage 1 requirements. Thank you.

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If you have any questions about completing this form, please call 813-974-4355 and speak with our Client Services Representative.

Thank you

As a result of the American Recovery and Reinvestment Act, the USF Physicians Group is required to collect patient data regarding race and ethnicity as part of information provided to the Centers for Medicare & Medicaid Services (CMS) under the Meaningful Use Stage 1 requirements. This information is required for all patients.

Would you please take a few extra moments to complete the attached form? We very much appreciate your assistance in helping us collect this information.

Race (Select One)

American Indian/Alaska Native
 Asian
 Black
 Unknown

Native Hawaiian/Other Pacific Islander
 White
 Declined

Ethnicity (Select One)

Hispanic or Latino or Spanish Origin
 Not Hispanic or Latino or Spanish Origin

Unknown
 Declined

Please note that you have the option of indicating “declined” above.

Language _____

Other required data to offer better service to you:

Preferred Method to Notify You of Upcoming Appointment (Select **One** Method Only As Your Preferred Contact)

_____ Name of Person to Confirm Appt With: _____

_____ Cell Phone Number _____

_____ Home Phone Number _____

_____ E-Mail – E-Mail Address _____

_____ Text Message – Phone Number to Text _____

_____ Do Not Call Me

_____ No Response

DATE ENTERED: _____ *BY:* _____ (*Initials*)