

Appendix 2

Dementia Register Form for persons not applying for anti-dementia medication D2	Registration no: (for office use only)
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Part 1: To be completed always:			
Name:		ID No:	
Surname:		DOB:	
Address:		Sex:	M <input type="checkbox"/> F <input type="checkbox"/>
Locality:		Post code:	

Part 2: To be completed when first diagnosed with dementia:			
Educational Level completed:	primary <input type="checkbox"/> secondary <input type="checkbox"/> post-secondary <input type="checkbox"/> non-tertiary <input type="checkbox"/> tertiary <input type="checkbox"/>	Social Status:	S M W Sep Div
Resident at:	Own Home <input type="checkbox"/>	Nursing Home <input type="checkbox"/>	Other <input type="checkbox"/>
Living status:	Alone <input type="checkbox"/>	With Spouse <input type="checkbox"/>	With Children <input type="checkbox"/>
Main Carer (name):		Main Carer (relation):	
Main Carer (Tel No):		Own telephone no:	
Referred by (GP):		Date of referral:	
Reason for referral:		Date of 1st attendance to specialist clinic:	
Diagnosis Status:		Date of Diagnosis:	
MMSE score:		Barthel Score:	
Dementia Sub-Type:	Alzheimer's Disease <input type="checkbox"/> Fronto-temporal Dementia <input type="checkbox"/> Other <input type="checkbox"/> Specify:	Vascular Dementia <input type="checkbox"/> Alcohol Related Dementia <input type="checkbox"/>	Mixed Dementia <input type="checkbox"/> Lewy-Body Disease <input type="checkbox"/>
Clinic:	RHKG <input type="checkbox"/> Community <input type="checkbox"/>	MDH <input type="checkbox"/> Other <input type="checkbox"/> Specify:	MCH <input type="checkbox"/>
Radiology:	CT	Date:	
	MRI	Date:	
	SPECT	Date:	
Behavioural and Psychological Sypt:	Wandering <input type="checkbox"/> Depression <input type="checkbox"/>	Aggression <input type="checkbox"/> Shouting <input type="checkbox"/>	Agitation <input type="checkbox"/>
Anti-dementia Medication:		Side-effects from Anti-dementia medication:	
Psychiatric Treatment :		Side-effects of psychiatric medication:	

Part 3: To be completed during all subsequent visits:			
Date of visit:			
MMSE score:		Barthel score:	
Anti-dementia Medication:		Side-effects from Anti-dementia medication:	
Psychiatric Treatment:		Side-effects of Psychiatric treatment:	
Current housing Location:	Own Home <input type="checkbox"/>	Nursing Home <input type="checkbox"/>	Other <input type="checkbox"/>
		Specify:	Specify:

Part 4: To be completed always:			
Consultant:		Signature:	
Reg No:			

Data protection statement: The Department of Health treats personal sensitive information in a confidential manner, and undertakes to comply with the Data Protection Act 2001. Details on this certificate will only be disclosed to Entities within this Division and any other authority/body as permitted by law.