

APPENDIX



Facilitation of Care Planning

BY _____	Date _____
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Patient's Details								
Affix Patient Sticky Label						Religion		
						Marital status		
Diagnosis of dementia <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes stage of disease <input type="checkbox"/> Early <input type="checkbox"/> Moderate <input type="checkbox"/> Advance <i>(at the time this form is filled)</i>			Year of diagnosis			
Current functional status <i>at time of filling up form</i>								
Verbal communication		<input type="checkbox"/> Relevant <input type="checkbox"/> Superficially relevant <input type="checkbox"/> Irrelevant <input type="checkbox"/> incomprehensible <input type="checkbox"/> no verbal output						
Feeding		<input type="checkbox"/> Independent <input type="checkbox"/> Need assistance <input type="checkbox"/> Dependent			NGT / PEG	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Caregiver details								
Direct caregiver (s)		1. 2.	Relationship to patient		1. 2.	<input type="checkbox"/> Main decision maker <input type="checkbox"/> Main decision maker		
Main decision maker (if different from direct care giver)			Relationship to patient			Living with patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Family's understanding of dementia								
Patient's understanding of dementia <input type="checkbox"/> No insight <input type="checkbox"/> Partial insight <input type="checkbox"/> Good insight <input type="checkbox"/> Not Applicable		Description of patient's understanding						
		Is dementia a terminal illness? (life limiting / fatal)				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Main decision maker's understanding of dementia <input type="checkbox"/> No insight <input type="checkbox"/> Partial insight <input type="checkbox"/> Good insight		Description of family's understanding						
		Is dementia a terminal illness? (life limiting / fatal)				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Prior dementia counselling		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes	When?		If No , dementia counselling by CPGP done	On	
				By whom?			By	



Facilitation of Care Planning

ACP – Introduction						
Introduction	When		Reading material given	<input type="checkbox"/> ACP brochure	Mailed/ Given on	
	By					
Outcome	<input type="checkbox"/> Keen <input type="checkbox"/> Not keen <input type="checkbox"/> Unsure	Comments				
Plan	<input type="checkbox"/> Follow up call in _____ <input type="checkbox"/> Family will inform when keen <input type="checkbox"/> Request not to bring up topic again			Staff stamp/ Name	Date	
Follow up						
Visit / Call Date		CPGP Staff		Spoken To		
Outcome	<input type="checkbox"/> Keen <input type="checkbox"/> Not keen <input type="checkbox"/> Unsure	Comments				
Plan	<input type="checkbox"/> Fix ACP appointment date. Appointment _____ <input type="checkbox"/> Follow up call in _____ <input type="checkbox"/> Family will inform when keen <input type="checkbox"/> Request not to bring up topic again			Staff stamp/ Name	Date	
<input type="checkbox"/> Please refer to follow up sheets for information or more follow up documentations.					Date	
ACP – Completion						
Date ACP done		Type of ACP done	<input type="checkbox"/> General ACP <input type="checkbox"/> PPC	Done by	<input type="checkbox"/> CPGP <input type="checkbox"/> CGH palliative Team <input type="checkbox"/> Other _____	
<input type="checkbox"/> Electronic copy <input type="checkbox"/> Hard copy in CPGP folder <input type="checkbox"/> Family has a hard copy		Comments				
Other support provided						
<input type="checkbox"/> "When A Loved One Passes Away" Guide given <input type="checkbox"/> NEA website given http://www.nea.gov.sg/public-health/care-for-the-dead/other-death-related-matters			<input type="checkbox"/> Palliative referral <input type="checkbox"/> GP list for death certification given			