CARE PARTNER FORM
Memory and Brain Wellness Clinic
NPI-Q & Care Partner Concerns

Important: This form is to be filled out by a CARE PARTNER (for example a family member or friend - *not the patient*). Please fill out both front and back.

Please answer the following questions based on recent behaviors. Circle **"Yes"** only if the **symptom(s) has been present in the last month**. Otherwise, circle "No". For each item marked **"Yes", please rate the SEVERITY** of the symptom as **mild, moderate, or severe**.	**Symptom present?**		**Severity (if symptom present)**		
	Yes (1)	**No (0)**	**Mild (1)**	**Mod. (2)**	**Sev. (3)**
Delusions: Does the patient have false beliefs, such as thinking that others are stealing from him or her or planning to harm him or her in some way?	○	○	○	○	○
Hallucinations: Does the patient have hallucinations? Does he or she seem to hear or see things that are not there? Does he or she talk to people who are not there?	○	○	○	○	○
Agitation or Aggression: Is the patient stubborn and resistive to help from others?	○	○	○	○	○
Depression or Dysphoria: Does the patient seem sad or act as if he or she is in sad or low spirits? Does he or she cry?	○	○	○	○	○
Anxiety: Does the patient become upset when separated from you? Does he or she have any other signs of nervousness or anxiety?	○	○	○	○	○
Elation or Euphoria: Does the patient appear to feel too good or act excessively happy?	○	○	○	○	○
Apathy or Indifference: Does the patient seem less interested in his or her usual activities or in the activities and plans of others?	○	○	○	○	○
Disinhibition: Does the patient seem to act with "fewer filters"? For example, is he or she unusually frank with words? Does he or she get too close physically or acts embarrassingly?	○	○	○	○	○
Irritability or Lability: Is the patient impatient and cranky? Does he or she have difficulty coping with delays or waiting for planned activities?	○	○	○	○	○
Motor Disturbance: Does the patient engage in repetitive activities such as pacing around the house, handling items over and over, or doing other things repeatedly?	○	○	○	○	○
Nighttime Behaviors: Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?	○	○	○	○	○
Appetite and Eating: Has the patient lost or gained weight, or had a change in the type of food he or she likes?	○	○	○	○	○

PROVIDER SIGNATURE	PRINT NAME	PAGER	NPI	TIME	DATE

PLACE PATIENT LABEL HERE

H2820

WHITE - MEDICAL RECORD

Do you have any concerns about the following (please check all that apply)	
☐	Falls
☐	Driving safety
☐	Wandering away and getting lost
☐	Unsafe behaviors around the house (e.g. leaving the stove on, or using power tools in an unsafe way)
☐	Forgetting to take medication, or taking too much
☐	Ability to manage money
☐	Substance use (e.g. drinking)
☐	Feeling unsafe or in danger as a care partner
☐	Recent physical changes (e.g. trouble swallowing, tremors, new onset weakness) – please describe below
☐	Other concerns – please describe below, if any

Overall, how stressful is your situation as a care partner at this time?

0 = **Not** stressful at all	1 = **Minimal** (slightly stressful, not a problem to cope with)	2 = **Mild** (not very stressful, generally easy to cope with)	3 = **Moderate** (fairly stressful, not always easy to cope with)	4 = **Severe** (very stressful, difficult to cope with)	5 = **Extreme or Very Severe** (extremely stressful, unable to cope with)
○	○	○	○	○	○

Informant: ○ Spouse ○ Child ○ Other (specify) _____

This section filled by staff only	**New**	**Return**	**Provider**							
	○	○	TG ○	KDR ○	RK ○	SDM ○	KC ○	AH ○	EL ○	AMC ○

PLACE PATIENT LABEL HERE

CARE PARTNER FORM
Memory and Brain Wellness Clinic
FAQ & ADLs

Important: This form is to be filled out by a CARE PARTNER (for example a family member or friend - *not the patient*). Please fill out both front and back.

In the past 4 weeks, did the patient have any difficulty or need help with:		Can do without any problems (0)	Has difficulty, but does by self (1)	Can do with help (2)	Fully dependent on others (3)	NEVER did this in his/her life (-)
1	Writing checks, paying bills, or balancing a checkbook	☐	☐	☐	☐	☐
2	Assembling tax records, business affairs, or other 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 public transportation	☐	☐	☐	☐	☐

PLACE PATIENT LABEL HERE

	Is the patient able to do the following:	Performs action independently **Yes (1)**	**No (0)**
1	**Bathing (sponge bath, tub bath, or shower)** – receives either no assistance or assistance in bathing only one part of the body	☐	☐
2	**Clothing** – gets clothes and dresses without any assistance except for tying shoes	☐	☐
3	**Toileting** – Goes to toilet room, uses toilet, arranges clothes, and returns without any assistance (may use cane or walker for support and may use bedpan/urinal at night)	☐	☐
4	**Transferring** – moves in and out of bed and chair without assistance (may use cane or walker)	☐	☐
5	**Continence** – controls bowel and bladder completely by self (without occasional "accidents")	☐	☐
6	**Feeding** – feeds self without assistance (except for help with cutting meat or buttering bread)	☐	☐

***Informant*:** ☐ Spouse ☐ Child ☐ Other (specify) _____

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