

## **Personalised Dementia Care Strategies Report**

Client's Name			
Client Reference Number			
Date of Birth			
Current Accommodation			
Primary Diagnosis			
Sources of Medical History			
Date of Consent			
Details of Person Providing Consent			
Name of Referrer			
Reason of Referral			
AQ Consultant/Assessor			
Date of Assessment			
Date of Recommendation			
Social History			
<b>Social History</b> (Place of birth, childhood, family and	nd relationships, employment, and personal hobbies/strengths)		
Recent Medical Events (Hospitalisation, falls, infection or medication changes)			

RES-F-132 Revision: 1 Date: 01/02/2021 Page 1 of 4 UNCONTROLLED COPY WHEN PRINTED



	<u>ement</u>	ia Care Strategies	Keport	
Client Observation	intove et	n with athorn)		
Appearance, orientation, affect, speech, gait, and	interactio	n with others)		
Cognitive Status				
Assessment Tool	Score	Indication		
Mini Mental State Examination				
Psychogeriatric Assessment Scale				
Rowland Universal Dementia Assessment				
Scale				
Cornell Depression Scale in Dementia				
Physical Assessment (Nutrition, pain, sleep, skin, bladder, and bowel function)				

Revision: 1 Date: 01/02/2021 UNCONTROLLED COPY WHEN PRINTED RES-F-132 Page 2 of 4



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Behaviour Care Plan	
Behaviour One	
Behaviour Description	
(what is it and whom it distresses)	
Impact of Pohaviour	
Impact of Behaviour (frequency and severity)	
(Hequency and Sevency)	
Possible Triggers	
(client, family, environmental or other factors)	
Personal Preferences or Choices	
reisonal Freierences of Choices	
Recommended Strategies	
Behaviour Two	
Behaviour Description	
<b>Behaviour Description</b> (what is it and whom it distresses)	
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## **Personalised Dementia Care Strategies Report**

Behaviour Three	
Behaviour Description (what is it and whom it distresses)	
Impact of Behaviour (frequency and severity)	
Possible Triggers (client, family, environmental or other factors)	
Personal Preferences or Choices	
Recommended Strategies	