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
(Place of birth, childhood, family and relationships, employment, and personal hobbies/strengths)

Recent Medical Events
(Hospitalisation, falls, infection or medication changes)

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Client Observation
Appearance, orientation, affect, speech, gait, and interaction 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)

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Behaviour Care Plan	
Behaviour One	
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	
Behaviour Two	
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	

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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	