LIAF *With you every step of the way*
LONG ISLAND ALZHEIMER'S FOUNDATION

DATE

## PROSPECTIVE PARTICIPANT INFORMATION

PARTICIPANT NAME GENDER

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ PARTNER ☐ WIDOWED

ADDRESS

CITY STATE ZIP

PERSONS LIVING IN HOUSEHOLD

TELEPHONE DATE OF BIRTH

HOW DID YOU HEAR ABOUT LIAF?

## PRIMARY CAREGIVER/EMERGENCY CONTACT INFORMATION

CAREGIVER NAME GENDER DATE OF BIRTH

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ PARTNER ☐ WIDOWED

ADDRESS

CITY STATE ZIP

TELEPHONE NUMBERS (home, work, cell) E-MAIL

CAREGIVER'S RELATIONSHIP TO PARTICIPANT

☐ SPOUSE ☐ PARTICIPANT'S SON/DAUGHTER ☐ PARTICIPANT'S SON/DAUGHTER IN-LAW ☐ PARTICIPANT'S PARENT

☐ SIGNIFICANT OTHER ☐ FRIEND/NEIGHBOR ☐ SIBLING ☐ OTHER (Specify): _____

## SECONDARY CAREGIVER/EMERGENCY CONTACT INFORMATION

CAREGIVER NAME GENDER DATE OF BIRTH

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ PARTNER ☐ WIDOWED

ADDRESS

CITY STATE ZIP

TELEPHONE NUMBERS (home, work, cell) E-MAIL

CAREGIVER'S RELATIONSHIP TO PARTICIPANT

☐ SPOUSE ☐ PARTICIPANT'S SON/DAUGHTER ☐ PARTICIPANT'S SON/DAUGHTER IN-LAW ☐ PARTICIPANT'S PARENT

☐ SIGNIFICANT OTHER ☐ FRIEND/NEIGHBOR ☐ SIBLING ☐ OTHER (Specify): _____

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PARTICIPANT NAME

COGNITIVE DIAGNOSIS

DATE OF DIAGNOSIS

DOES THE PARTICIPANT HAVE LONG-TERM CARE INSURANCE?

IF SO, WHO IS THE CARRIER?

## MEDICAL INFORMATION

MEDICAL HISTORY/DIAGNOSES (i.e. Heart Disease, Diabetes, etc. + surgical history with dates)

MEDICATION (list all with dosage)

ALLEGIES

DIETARY RESTRICTIONS

PRIMARY PHYSICIAN

TELEPHONE

FAX

PHYSICIAN(S) TREATING MEMORY LOSS (i.e. Neurologist, Geriatrician, Psychiatrist, etc.)

TELEPHONE

FAX

DOES THE PARTICIPANT HAVE A DNR (DO NOT RESUSCITATE)? IF SO, PLEASE PROVIDE.

☐ YES ☐ NO

*I certify that the participant does not have any known communicable diseases.*

PARTICIPANT SIGNATURE

CAREGIVER SIGNATURE

DATE