brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

PRE-ENROLLMENT QUALIFICATION ASSESSMENT TOOL FOR DEMENTIA (HMO CSNP)

First Name:	MI:	Last Name:
Gender: ☐ Male ☐ Female	DOB:	

CLINICAL QUALIFYING QUESTIONS

If any of the following are checked, candidate pre-qualifies.

Have you ever been told by a doctor that you have any of the following illnesses? (Check all that apply)

- ☐ Dementia
- ☐ Parkinson's Disease
- ☐ Frontotemporal Dementia (FTD)
- ☐ Picks (PiD)
- ☐ Mild Cognitive Impairment (MCI)
- ☐ Dementia with Lewy Bodies (DLB)
- ☐ Alzheimer's Disease
- ☐ Creutzfeldt-Jakob Disease (CJD)
- ☐ Huntington's Disease (HD)
- ☐ Vascular Dementia
- ☐ Multi-Infarct Dementia (MID)
- ☐ Normal Pressure Hydrocephalus (NPH)

MEDICATION QUESTIONS

1. Are you now or have you ever taken medication for an illness listed above? ☐ Yes ☐ No
2. What medications are you currently taking? ______________________________

PRIMARY PHYSICIAN: ______________________________

Name of Physician

____

His/her clinic or location and phone number

SPECIALIST: ______________________________

Name of Specialist

____

His/her clinic or location and phone number

Candidate Signature:	Date: