**ENTER YOUR LETTERHEAD HERE**

**Assessment and Recommendations for Care**

**Client Name:**

**Referred By:**

**Assessment Date:**

**Summary:**

**Client Profile:**

**Demographics:**

**Current Living Arrangement**:

**Address:**

**Home Phone**:

**Cell Phone:**

**Email:**

**Original Move-In Date:**

**Date of Birth**:

**Marital Status**:

**US Citizen**:

**Veteran**:

**Religious Preference**:

**Place of Worship:**

**Family Members - Contact Information**

Name:

Address:

Contact Telephone #:

Email address:

Designate emergency contact:

**Medical Information**

**List of Health Care Providers** (include primary care; all specialists, dentist, ophthalmologist, audiologist, therapists, etc.)

(Information Needed for Each)

**Physician**:

**Specialty:**

**Address**:

**Phone**: **Fax**:

**Last visit**:

**Next scheduled visit:**

**Current Medical diagnoses**:

**List Past Medical and Surgical History**

**Recent Urgent Care Visits, ER, Hospitalizations and Rehabilitation Stays:**

**Medical Procedures/X-rays/Labs:** (such as colonoscopy, EKG, labs, mammography, etc.)

**Current Medical Concerns**: (such as falls, memory loss, etc.)

**Vaccinations: (such as flu, tetanus, shingles, pneumococcal)**

**Smoking history**:

**Alcohol Consumption**:

**Communication:** (ability to express needs)

(communication tools such as phone, computer, cell phone, text)

**Diet:**  Type of diet; any preferences; dislikes

**Height:**

**Weight: (any unusual weight gain or loss)**

**Appetite:**

**Hearing Aids**:

**Vision**:

**Dentition**:

**Driving**: (if not type of transportation)

**Pets**:

**Mobility**

**Assistive Device**:

**Impairments**:

**Fall Risks**:

**Allergies**: (environmental, food, medication)

**Medication Intolerances**:

**Special Medication Instructions**:

**Medications:**

(Include prescription, supplements, vitamins, OTC’s, topical creams)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Scheduled Prescriptions** | **Dosage** | **Route** | **Frequency** | **Ordering MD** |
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| **As Needed Prescriptions** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Who is responsible for managing medications; refilling prescriptions; filling pill boxes; etc.?

**Pharmacy Information**

**Local Community Pharmacy:**

**Mail Order Pharmacy**: **Phone**:

Are medications delivered or picked up?

**Insurance Information**

**Traditional Medicare Card Number:**

**Name as it appears on card:**

**Supplemental Insurance Policy**:

**Long Term Care Insurance**:

**Pharmacy Prescription Card**:

**Legal Information**

**Advanced Directive:**

**Healthcare Power of Attorney**:

**Financial Power of Attorney**:

**Guardianship/Conservatorship**:

**Do Not Resuscitate Order**:

**Estate Plan (Will/Trust):**

**Elder Care Attorney**: **Phone**:

**Address**:

**Burial Information**

**Plot Location:**

**Address:**  **Phone**:

**Prepaid Arrangements**:

**Funeral Director/Home**: **Phone**:

**Social Information**

**Relationships:**

**Occupations:**

**Hobbies:**

**Interests:**

**Psychosocial**

**Past interests:**

**Present interests:**

**Self-Esteem**:

**Past stress:**

**Recent stress**:

**Grieving Behavior**:

**Judgment**:

**Concentration**:

**Relationships with Family**:

**Cognitive Abilities**

**Oriented (Person, Place, Time):**

**Mood:**

**Anxious**:

**Depressed**:

**Memory**

(memory assessment tool; any neurological evaluation?)

**Short Term:**

**Mid-Term:**

**Long Term**:

**Functional Assessment**

***ADLs (Activities of Daily Living)*** are defined as those tasks that are basic, routine in nature in and around the residence, including getting around inside the home, getting in and out of bed or a chair, bathing, dressing, eating, and toileting.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ADL for** | **Independent** | **Needs Minimal Assistance** | **Needs Moderate Assistance** | **Needs Maximum Assistance** | **Needs Total Assistance** |
| **Bathing & Grooming** |  |  |  |  |  |
| Comment: | | | | | |
| **Dressing** |  |  |  |  |  |
| Comment: | | | | | |
| **Toileting** |  |  |  |  |  |
| Comment: | | | | | |
| **Ambulating** |  |  |  |  |  |
| Comment: | | | | | |
| **Transfers** |  |  |  |  |  |
| Comment: | | | | | |
| **Eating** |  |  |  |  |  |
| Comment: | | | | | |

***IADLs (Instrumental Activities of Daily Living)*** are those tasks that require more complex mental and physical ability to carry out and directly relate to the maintenance of one’s safety in the home. They include going outside the home, keeping track of money and bills, preparing meals, doing light housework, laundry, taking prescription medication in the right amount at the right time, making and keeping appointments, and using the telephone.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **IADL for client** | **Independent** | **Needs Minimal Assistance** | **Needs Moderate Assistance** | **Needs Maximum Assistance** | **Needs Total Assistance** |
| **Managing Medications** |  |  |  |  |  |
| Comment: | | | | | |
| **Meal Preparation** |  |  |  |  |  |
| Comment: | | | | | |
| **Managing finances** |  |  |  |  |  |
| Comment: | | | | | |
| **Shopping** |  |  |  |  |  |
| Comment | | | | | |
| **Laundry** |  |  |  |  |  |
| Comment: | | | | | |
| **Light housekeeping** |  |  |  |  |  |
| Comment: | | | | | |
| **Talking on the Phone** |  |  |  |  |  |
| Comment: | | | | | |

**Home Environment/Safety Issues**

Emergency Response System

Lighting

Flooring (scatter rugs)

Bathroom (grab bars; shower seat, hand shower)

Smoke Alarm

Telephone Accessibility

Trip Hazards

Footwear

**Ancillary Services Currently in Place**

**Private Home Care**:

**Home Health:**

**Palliative Care**:

**Presenting Problems/Issues**

**Identified by family of client:**

**Goals Identified by Family and Client**

**Immediate Recommendations/Plan of Action**