File #: ___________________________________

Long Term Care
and
Community Support Program

Adult Needs Assessment

AUGUST 2008

Adapted from: Provincial Continuing Care Adult Long Term Care Assessment, revised 1999;
Community Living and Supportive Services Client Assessment, December 2001

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File #: ___________________________

AGENCY PROFILE

RHA: ____________________ Assessment Site: ________________ Assessment Date (y/m/d): ______________

Assessor's Name (Print): ________________________ Profession: ______________ Telephone #:_____________

Consent for Release of Information

The assessor must obtain consent for release of information in accordance with Regional Health Authority policy.

It may not be appropriate to obtain the consent at the beginning of the assessment process, but the client must be made aware that a written consent is required.

CLIENT PROFILE

Personal Data

Name: ____
Last First Middle Maiden Name

Permanent Address: ______________________________ Current Address: ______________________________

Mailing Address: ______________________________ Mailing Address: ______________________________

Telephone #: ______________________________ Telephone #: ______________________________

Directions to Current Address (if applicable): ____

DOB (y/m/d): ____________ Gender: ______ Religion (Optional): ________

Status: ☐ Single ☐ Married duration: _____ ☐ Widowed year: _____ ☐ Divorced year: _____ ☐ Common Law duration: _____

Language	Spoken	Written
English	☐	☐
French	☐	☐
Other	☐	☐

Is client able to:
Read? ☐ Yes ☐ No
Write? ☐ Yes ☐ No
Education level completed: _________

Does client require an interpreter:
☐ Yes ☐ No
Name of Interpreter: ______________
Telephone #: __________________

Occupation: ______________ Retired: ☐ Yes ☐ No Ethnic Background (Optional): ________________
Place of Birth: ______________________________
Father's Name: Last: __________________ First: ____________ Place of Birth: ________________
Mother's Maiden Name: Last: ______________ First: ____________ Place of Birth: ________________

Identification Numbers

MCP: ________________ Expiry Date: __________ (OAS/GIS): ___________ VAC (DVA): ____________
Veterans Status: ___________SIN: __________________ HRLE: ________________ CRMS: __________
Private Insurance: ____________________ Other: ______________________________________

Spousal Data (If Applicable)

Name: ____________________________ Age: ______ Telephone # Residence: ________________
Address (if different from client): ____________________ Business: ________________
____
Postal Code: ____________________________

Is spouse in receipt of services: ☐ No ☐ Yes, if yes ☐ Community Based ☐ DVA ☐ Other (specify)

Comments: ____

File #: ______________________

Provider of Information

Is the client providing all the information for the completion of this assessment? ☐ Yes ☐ No

If no, specify the reason, the name, telephone number and relationship of the person assisting with/providing the information:
____

REFERRAL PROFILE

Name of Person Initiating Referral: ______________________ Relationship to Client: ______________________
Address: ______________________ Telephone #: Residence: __________ Business: __________
Referral date (y/m/d): ______________________

If client is in hospital: Hospital Admission Date (y/m/d): __________ Medical Discharge Date (y/m/d): __________
What recent event(s) precipitated this assessment? ______________________
____
____
____
____

POWER OF ATTORNEY . ENDURING POWER OF ATTORNEY . GUARDIANSHIP . TRUSTEE

Specify Type: ______________________
Name: ______________________
Address: ______________________
____

Postal Code: ______________________

Telephone #: Residence: ______________________
Business: ______________________
Relationship: ______________________
Comments: ______________________
____

Specify Type: ______________________
Name: ______________________
Address: ______________________
____

Postal Code: ______________________

Telephone #: Residence: ______________________
Business: ______________________
Relationship: ______________________
Comments: ______________________
____

CONTACTS

EMERGENCY CONTACTS

Name: ______________________
Address: ______________________
____
Postal Code: ______________________
Telephone #: Residence: ______________________
Business: ______________________
Relationship: ______________________

Name: ______________________
Address: ______________________
____
Postal Code: ______________________
Telephone #: Residence: ______________________
Business: ______________________
Relationship: ______________________

FAMILY CONTACTS

Name: ______________________
Address: ______________________
____
Postal Code: ______________________
Telephone #: Residence: ______________________
Business: ______________________
Relationship: ______________________

Name: ______________________
Address: ______________________
____
Postal Code: ______________________
Telephone #: Residence: ______________________
Business: ______________________
Relationship: ______________________

File #: ____________________

ADVANCE HEALTH CARE DIRECTIVE (AHCD)

Is there an Advance Health Care Directive? ☐ Yes ☐ No Location: ____________________
Name of Substitute Decision Maker(s): ____________________
Address: ____________________ Telephone #: Residence: ____________________
____________________ Business: ____________________
Postal Code: ____________________
Have burial arrangements been made? ☐ Yes ☐ No If yes, complete Appendix A.

ORIENTATION/COGNITION

At the time of this assessment, the client is:
☐ Responsive
☐ Drowsy, but responsive to verbal commands
☐ Drowsy, responsive only to touch
☐ Non-responsive

Comments: ____________________
____

Is client oriented to:	Person?	☐ Yes	☐ No
	Time?	☐ Yes	☐ No
	Place?	☐ Yes	☐ No

Comments: ____________________
____

Has there been a change in client's orientation? ☐ Yes ☐ No

If yes, record change and duration: ____________________
____
____

COMPLETE THE STANDARDIZED MINI-MENTAL STATE EXAMINATION (SMMSE): **Only if**

- the answers to the above questions are no; or
- your observation, client history or family comments indicate there is a need; or
- there is not clear documentation as to the level of cognitive impairment.

The SMMSE may be done, if necessary, at the end of the assessment or at another more appropriate time.
Do not administer the SMMSE: If the client

- is illiterate; or
- has an intellectual disability.

Comments: (Complete when SMMSE **not** completed):
____
____
____
____
____
____
____
____
____

File #: ______________________________

PHYSICAL ASSESSMENT

Current Health Problems/Diagnoses (Please indicate MRSA/VRE/C.Difficile/Hepatitis status):

Health History (Briefly describe – e.g., dates/number/type/duration of hospital admissions):

Surgery (from most recent)	Date (y/m/d)	Surgery (from most recent)	Date (y/m/d)

Allergies/Sensitivities	Specify - Sensitivity or Allergy	Type of Reaction
☐ None Known		
☐ Medication		
☐ Food		
☐ Environment		
☐ Other		

Health Care Practitioners

Name	Specialty	Frequency of Visits

File #: ____________________

Screening

Women's Health

Has client ever had a mammogram? ☐ Yes Date: __________ ☐ No
Does client do breast self-examination? ☐ Yes ☐ No
Does client have an annual Pap test? ☐ Yes Date: __________ ☐ No

Comments: ____________________

Has client had a hysterectomy? ☐ Yes Date: __________ ☐ No

Comments: ____________________

Men's Health

Does client do testicular self-examination? ☐ Yes ☐ No
Does client have an annual rectal exam? ☐ Yes Date: __________ ☐ No

Comments: ____________________

Vaccines/TB Screening

Vaccines ☐ Family/Client Unaware
If known, date given y/m/d: Influenza:__________ Tetanus:__________ Pneumococcal:__________

TB Screening: Has the client had a tuberculin skin test? ☐ Yes ☐ No If yes, type of reaction:__________
Has the client ever had a BCG vaccination? ☐ Yes ☐ No

Date of last Chest X-Ray (y/m/d):__________

Comments: ____________________

Has the client had tuberculosis? ☐ Yes ☐ No ☐ Unknown Date (y/m/d) __________
Area/body part affected?__________

Comments: ____________________

Has the client had contact with any individual who has had tuberculosis? ☐ Yes ☐ No ☐ Unknown

Comments: ____________________

Does the client have:
☐ Chronic cough (› 4 weeks duration)
☐ Fever (› 1 week duration)
☐ Bloody Sputum
☐ Weight loss
☐ Night sweats

If yes, refer to physician.
Comments: ____________________

If the client was born after 1950, records may be accessed by contacting your local Public Health Office.

File #: ________________________________

Medications

List all medications, including dosage, frequency, route, prescriber, and pharmacy.

(A) Prescribed Medication	Dosage	Frequency	Route	Prescriber	Pharmacy

(B) Non-prescription & alternative forms of medicine (over-the-counter -such as herbs, oils, vitamins, etc.)	Dosage	Frequency	Route

Frequency	od - daily	bid - twice daily	tid - 3 times daily	qid - 4 times daily	hs - bedtime
Route	po - oral	sl - sublingual	sc - subcutaneous	im - intramuscular	iv - intravenous
		td – transdermal	r - rectally	oth – other (e.g., eye drops)	

Can client self-medicate? ☐ Yes ☐ No Authorization for delegation of function required? ☐ Yes ☐ No
Medication review requested? ☐ Yes ☐ No

Comments: (Include ability to manage medications, including obtaining prescriptions, safety, compliance, abuse, incompatibilities and monitoring drug levels.)

____

____

Does client require special authorization for medications? ☐ Yes ☐ No
If yes, has this authorization been requested?

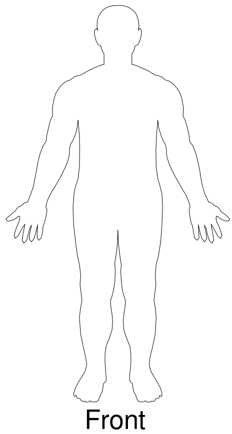
____

File #: ___________________________

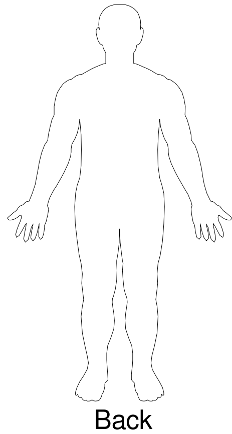
Pain

Acute Pain: ☐ Yes ☐ No
Site & Frequency ___________________________

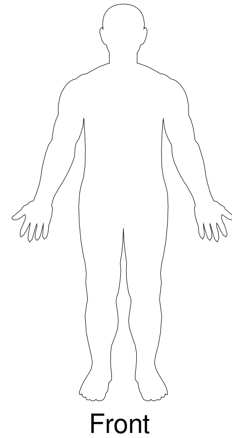
Chronic Pain: ☐ Yes ☐ No
Site & Frequency ___________________________



Front



Back



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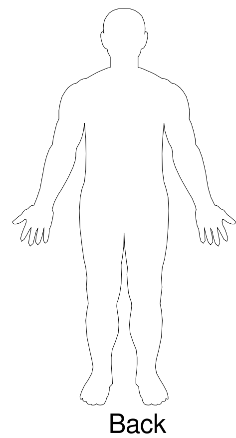


Back

Limitations due to pain (Acute and Chronic)

☐ Pain does not interfere with daily activities
☐ Pain limits participation in some types of daily activities
☐ Pain limits participation in most daily activities

Pain Management (Acute and Chronic)

☐ Physiotherapy
☐ Massage Therapy
☐ Medication
☐ Heat/Cold
☐ TENS (Transcutaneous electric nerve stimulation)
☐ Splints
☐ Other (Specify)
____
____

Is pain management satisfactory? ☐ Yes ☐ No
Comments:
____
____

See Appendix B – Pain Assessment Tools for optional measurable indicators of pain.

Skin Integrity

☐ Skin intact
☐ Skin intact, but at risk of breakdown from poor circulation, immobility or nutritional status
☐ Wounds, lesions, rashes or ulcers present – Specify site: ___________________________

Comments: type of skin care (e.g., turning, dressings), and who manages care. Note if new or long-standing infection is present.
____
____
____

File #: ____________________

Respiration

☐ Normal Respiration Pattern
☐ Experiences fatigue, or shortness of breath with activity
☐ Experiences fatigue or shortness of breath with limited or no activity

Respiratory Care

Respiratory Care	Independent	Requires Assistance
☐ Nebulization Therapy	☐	☐
☐ Tracheotomy Care	☐	☐
☐ Oxygen: ☐ Concentrator	☐	☐
☐ Liquid	☐	☐
Continuous	☐	☐
Intermittent	☐	☐
☐ Nasal/Oral Suctioning	☐	☐
☐ Respirator/Ventilator	☐	☐
☐ Chest Physiotherapy	☐	☐
☐ Postural Drainage	☐	☐
☐ CPAP (Continuous Positive Airway Pressure)	☐	☐
☐ BiPAP (Bilevel Positive Airway Pressure)	☐	☐

Comments: ____________________

Circulation

☐ No cardiovascular or peripheral vascular symptoms apparent
☐ Symptoms do not interfere with most activities
☐ Easily fatigued; limits some activities
☐ Other: ____________________
☐ Dependent edema
☐ Pulse irregularities
☐ Symptoms severely limit activities

Comments: (e.g., pacemaker, Hickman catheter, PICC, CVP). Management of circulatory care (e.g., activity restrictions, thromboembolic stockings, positioning). ____________________

Vision (with visual aids)

☐ Adequate Vision
☐ Inadequate Vision:
- ☐ Mild Impairment
- ☐ Moderate Impairment
- ☐ Legally Blind

☐ Totally Blind

Client has:
☐ Prescription eyeglasses
☐ Contact lenses
☐ Magnifying glass
☐ Eye prosthesis
☐ Cataracts

Date of last eye examination: ____________________
Eyeglasses/contact lenses – where purchased ____________________ Date: ____________________
Comments: ____________________

Hearing

☐ Hears normal speech with or without aids
☐ Has difficulty even with hearing aid or when spoken to clearly
☐ Totally deaf; unable to hear loud noises
☐ Hearing has not been tested
☐ Hearing has been tested by: ____________________
Date (y/m/d):____________________
☐ Hearing Aid: ☐ Left Ear ☐ Right Ear

Comments: ____________________

File #: ____________________

Communication

(Include speech, sign language, gestures, symbol board or writing)

Expressive Communication

☐ Communicates effectively
☐ Can communicate most needs; is understood with difficulty
☐ Can communicate only basic needs; uses only syllables/gestures
☐ Unable to communicate by any means

Comments (indicate if client is non-verbal):
____
____
____

Receptive Communication

☐ Understands all verbal/non-verbal communication
☐ Understands most communication; has difficulty with complex concepts
☐ Uses lip reading/sign language/written material to communicate
☐ Understands only basic words, gestures, facial expressions, simple pictures or environmental cues
☐ Unable to understand any communication

Comments (e.g., tools used to help client communicate)
____
____
____

Nutrition

Appetite (client report) ☐ Good ☐ Fair ☐ Poor
Has client had recent change in appetite? ☐ No ☐ Yes Explain: ____________________
Current weight: Actual ____________ Approximate: ____________
Has client had a recent change in weight? ☐ No ☐ Yes Explain: ____________________
How many times a day does the client have something to eat? Meals: ____________Snacks: ____________
How many cups of fluid does client drink in a day (including tea/coffee)? Specify: ____________________
Does the client include foods from: ☐ Cereal and Grain ☐ Fruit and Vegetables ☐ Milk ☐ Meat and Alternatives
Does the client have a special diet? ☐ Yes ☐ No Specify: ____________ Supplement:____________
Does food require special preparation? ☐ Yes ☐ No Specify: ____________________
Comments (e.g., who prepares meals): ____________________
____
____

Tube feeding (if applicable)
Route: ____________________ Frequency: ____________________
Type: ____________________ Extra water (amount): ____________________
Amount: ____________________
Comments (e.g., time of day): ____________________
____
____

Dental/Oral Hygiene

☐ Own teeth

☐ No teeth
☐ Dentures
  ☐ Upper
  ☐ Lower
☐ Partial plate
☐ Poor fitting dentures
☐ Other prosthesis - Specify: ____________________

☐ Problems chewing
☐ Mouth lesions
☐ Dry mouth

☐ Altered taste or smell
☐ Frequent indigestion
☐ Choking/swallowing problems
Specify: ____________________
____

Date of last dental examination: ____________________

Comments: ____________________
____
____

File #: ___________________________________

Nausea

Does client have episodes of nausea? ☐ Yes ☐ No
If yes, when does it occur?____________________
Frequency/Time/Duration:____________________

Vomiting

Does client have episodes of vomiting? ☐ Yes ☐ No
If yes, when does it occur?________________________________
Frequency/Time/Duration:________________________________

Comments: ____
____

Sleep Pattern

☐ Sleeps well; regular day/night routine
☐ Sleeps with sedation at night
☐ Disrupted sleep pattern, but safe on own
☐ Disrupted sleep pattern, requires intermittent supervision
☐ Disrupted sleep pattern, requires constant supervision
☐ Disrupted sleep pattern, frequency ______________

Comments (Include nature of disrupted sleep pattern – noisy, insomnia, requires light, etc.): __________________________
____
____

Urinary/Bowel Function

Urinary
☐ Continent
☐ Incontinent
☐ Catheter: Intermittent __ Indwelling __ Self-catheterization __
☐ Ostomy
☐ Stress Incontinence
☐ New ☐ Long standing problem

Bowel
☐ Continent
☐ Incontinent
☐ Ostomy
☐ New ☐ Long standing problem

Comments (Indicate current management, incontinence products used, bowel regime): ______________________________
____
____

Foot Care

☐ One or more foot problems
(e.g., corns, calluses, bunions, hammer toes, over lapping toes, pain, structural problems)
☐ Infection of the foot (e.g., cellulitis, purulent drainage)
☐ Open lesions on the foot
☐ nails or calluses trimmed during last 90 days
☐ preventative or protective foot care
(e.g., special shoes, inserts, pads, toe separators)
☐ application of dressings (with or without topical meds)

Regular foot care provided by: ☐ VON ☐ Caregiver ☐ Other

Comments: ____
____
____

Risk/History of Falls

☐ Not Applicable
☐ Fell in last 30 days
☐ Fell in last 31 – 180 days
☐ Hip fracture in last 180 days
☐ Other fracture in last 180 days

Comments: ____
____

File #: ______________________________

Physical Function

☐ No limitations
☐ Impaired Sensation
☐ Weakness
☐ Contractures
☐ Fractures
☐ Hemiplegia ☐ Left ☐ Right

☐ Paraplegia
☐ Quadriplegia
☐ Amputation – Body Part ______________________
☐ Limited Joint ROM (range of motion)
Joint (s) affected: ______________
____

Comments: ____
____
____

Mobility

	Without Aid	With Ambulatory Aids	With Wheelchair	
Independent (indoor)	☐	☐	☐	☐ Bed to chair only
Independent (outdoor)	☐	☐	☐	☐ Confined to bed
Minimal assistance	☐	☐	☐	
One person assistance	☐	☐	☐	
Two person assistance	☐	☐	☐	

Comments: ____
____
____

Activity Tolerance

☐ No difficulty
☐ Becomes fatigued with strenuous activity (e.g., climbing stairs)
☐ Becomes fatigued with low to moderate activity (e.g., walking)
☐ Unable to tolerate any activity (e.g., sitting in a chair for any length of time)

Comments: ____
____
____

Equipment/Assistive Devices Used

☐ None required

Cane: ☐ Regular
☐ Quad

Walker: ☐ Wheels
☐ No Wheels

Wheelchair: ☐ Standard
☐ Electric

☐ Geriatric Chair
☐ Braces/Splints
☐ Orthotics
☐ Prostheses
☐ Mechanical Lift

Bedroom Equipment:

☐ High/Low Bed
☐ Air Mattress
☐ Water Mattress
☐ Trapeze or Overhead Bar
☐ Side Rails
Other: ______________ (Specify)

Bathroom Aids:

☐ Raised Toilet Seat
☐ Grab Bars
☐ Commode
☐ Urinal/Bed Pan
☐ Bath/Shower Seat
Other: ______________ (Specify)

Comments (e.g., Special Assistance Program/Private Purchase): ______________________________
____
____
____

File #: ______________________________

PHYSICAL ACTIVITIES OF DAILY LIVING

Physical Activities of Daily Living		Ind	Min	Mod	Dep	TD	N/A	COMMENTS (Refer to specific ADL when commenting, ie. ambulation)
Grooming (ie., facial wash, mouth care, combing hair, etc.)								
Shaving								
Hair Care (Shampoo, style, etc.)								
Skin Care								
Hand Care	Wash Hands							
	Trim Nails							
Foot Care	Care for Feet							
	Trim Nails							
Bathing	Tub/Shower							
	Sponge							
	Bed							
Dressing	Upper Extremities							
	Lower Extremities							
Eating								
Toileting								
Ambulation								
Transfer								
Turning/Positioning								

(Ind)	Independent	needs no assistance, may use special devices
(Min)	Minimal Assistance/Cueing	needs reminding or occasional supervision/assistance
(Mod)	Moderate Assistance/Supervision	needs intermittent supervision or assistance to complete some tasks, may use special devices
(Dep)	Dependent/Constant Supervision	needs constant critical watching to give direction or complete task or someone else to perform function
(TD)	Technology Dependent	needs a medical device to compensate for loss of a vital body function and ongoing professional care, e.g., ventilator, etc.
(N/A)	Not Applicable	does not apply

Assessor: ________________________ Profession: ______________________ Telephone #: _______________ Date: _______________

File #: ___________________________

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Instrumental Activities of Daily Living		Ind	Min	Mod	Dep	N/A	COMMENTS (Refer to specific IADL when commenting, ie. shopping)
Meal Preparation							
Home Management	Laundry						
	Bathroom/Kitchen						
	Bedmaking/Dusting						
	Light Vacuuming						
	Other						
Ability to use Telephone							
Personal Financial Affairs							
Medication							
Transportation							
Shopping							
Yard Work							
Snow Removal							

(Ind)	Independent	needs no assistance, may use special devices
(Min)	Minimal Assistance/Cueing	needs reminding or occasional supervision/assistance
(Mod)	Moderate Assistance/Supervision	needs intermittent supervision or assistance to complete some tasks, may use special devices
(Dep)	Dependent/Constant Supervision	needs constant critical watching to give direction or complete task or someone else to perform function
(N/A)	Not Applicable	does not apply

Assessor: ________________________ Profession: ______________________ Telephone #: ______________ Date: ______________

File #: ___________________________

BEHAVIORAL ASSESSMENT

The following questions refer to problems that may be evident during the client assessment. Whenever possible, the information should be obtained from a resource person.

Information provided by: ____________________ Relationship: ______________________

Smoking Behavior

☐ Not Applicable

☐ Client smokes ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other, Specify: __________

☐ Safety risk ☐ Lighted cigarettes left unattended ☐ Disposes cigarettes inappropriately ☐ Smokes in bed

Comments (Frequency/amount): ____
____
____

Substance Abuse

☐ Not Applicable

	Alcohol	Non-Prescription Drugs	Prescription Drugs
Infrequent or no use	☐	☐	☐
Use does not impair day-to-day functioning	☐	☐	☐
Use impairs functioning	☐	☐	☐

Comments: ____
____
____

Wandering

☐ Wandering behavior not apparent
☐ Wanders, does not leave familiar environment
☐ Wanders beyond familiar environment
☐ Potential to wander
☐ Is registered with a client registry
☐ Wanders at certain times of day
☐ Is upset after wandering

Comments (Describe actual behavior, frequency, time of day, what provokes and strategies to minimize): __________
____
____
____

Hoarding/Rummaging

☐ Not applicable
☐ Hoards food or objects picked up in environment but does not search others' belongings
☐ Searches others' belongings looking for food or objects
☐ Specific places where things are normally stored: ______________________________
☐ Specific things to keep out of reach: ______________________________________

Comments (Describe actual behavior, frequency, time of day, what provokes and strategies to minimize): __________
____
____

File #: ______________________________

Social Behavior

☐ Cooperative and socially appropriate
☐ Bosses and manipulates others
☐ Uses angry language directed at others

Comments (Describe actual behavior, frequency, time of day most often occurs, what provokes and strategies to minimize):
____
____
____
____

Aggressive Behavior

☐ Not applicable ☐ Behavior management referral

Verbal
☐ Exhibits verbal hostility when approached or touched
☐ Exhibits verbal hostility spontaneously
☐ Demonstrates violent temper
☐ Displays temper tantrums
☐ Threatens physical violence

Physical
☐ Strikes out physically when approached or touched
☐ Strikes out physically spontaneously

Comments (Describe history, actual behavior, frequency, time of day, what provokes and strategies to minimize): __________
____
____
____
____

Self-Injurious Behavior

☐ Not applicable ☐ Behavior management referral

☐ Self-injurious behavior results in minimal injury
☐ Self-injurious behavior results in injury requiring medical attention

Comments (Describe history, actual behavior, frequency, time of day, what provokes and strategies to minimize): __________
____
____
____
____

Sexual Behavior

☐ Not applicable ☐ Behavioral management referral made

☐ Inappropriate sexual comments directed to others
☐ Public touching of genitals or masturbation
☐ Public exposure of genitals or other private parts
☐ Sexual interest in children
☐ Inappropriate touching of others

Comments (Note whether evidence obtained through observation, interview or past history; describe actual behavior, frequency, time of day, what provokes and strategies to minimize): ______________________________
____
____
____
____

File #: ______________________________

MENTAL HEALTH ASSESSMENT

Mental Health History

☐ Client does not have a history of psychiatric illness
☐ Client has a history of psychiatric illness: ☐ acute ☐ chronic
☐ Family history of psychiatric illness

Comments: ______________________________

Potential for Suicide

☐ Suicidal tendencies not apparent
☐ Verbalizes ideas of suicide, no prior threats or attempts
☐ Verbalizes ideas of suicide
☐ Verbalizes plans for suicide
☐ Has previously attempted suicide
☐ Family history of attempted/actual suicide

Comments: ______________________________

Mental Health Indicators

☐ Pleasant
☐ Co-operative
☐ Flat Affect
☐ Fearful
☐ Agitated
☐ Tearful
☐ Preoccupied
☐ Anxious
☐ Withdrawn
☐ Paranoid and/or Suspicious
☐ Lethargic
☐ Obsessive Behavior
☐ Preoccupation with Physical Complaints
☐ Inappropriate in Thought or Action
☐ Excessively Talkative
☐ Depressed
☐ Labile

Comments (List changes which have occurred in the past year): ______________________________

File #: ___________________________

SOCIAL ASSESSMENT

Household Composition (Check all applicable responses)

☐ Alone ☐ Spouse & Children ☐ Parents ☐ Non-Relatives
☐ Spouse/Partner ☐ Children ☐ Other Relatives ☐ Homeless

Specify if in supported living arrangement ☐ AFC ☐ Co-op Apartment ☐ ILA ☐ PCH ☐ NH ☐ B/L ☐ Shared

Caregiver Coping Capacity: ☐ Coping ☐ Requires assistance/respite ☐ Requires high level assistance ☐ Ineffective Coping

Comments: ____

____

Contact with Relatives

	Telephone	Visit
Once a day or more	☐	☐
2 - 6 times weekly	☐	☐
Once weekly	☐	☐
Once a month	☐	☐
Special occasions	☐	☐
Not at all	☐	☐

Contact with Friends

	Telephone	Visit
Once a day or more	☐	☐
2 - 6 times weekly	☐	☐
Once weekly	☐	☐
Once a month	☐	☐
Special occasions	☐	☐
Not at all	☐	☐

Comments: ____

____

Supports Available (Persons available and willing to provide assistance/support)

Name	Relationship	Telephone #	Type of Support

Comments: ____

____

Employment/Training Program Status (If applicable)

☐ Not applicable

Employed:	Attends School:	Attends Training:	Other:
☐ Full Time	☐ Full Time	☐ Full Time	☐ Retired
☐ Part Time	☐ Part Time	☐ Part Time	☐ Volunteer
☐ Supported Employment			
☐ Awaiting job placement			

	Name	Address	Contact Person / Telephone #
Employer			
School			
Training Program			

☐ Support not required ☐ Requires minimal support ☐ Requires intermittent support ☐ Requires constant support

Comments: ____

____

File #: ____________________

Coping Skills

☐ Reacts well to change
☐ Does not react well to change
☐ Requires some assistance in sorting out feelings
☐ Requires much assistance in sorting out feelings

Comments: ____________________

Leisure/Recreation/Hobbies

☐ Independently plans and carries out activities
☐ Plans, but cannot carry out activities
☐ Requires some assistance identifying/planning activities but can do them independently
☐ Requires full assistance planning activities but can do them independently
☐ Requires full assistance with all activities
☐ Does not participate

Comments: ____________________

Community Participation

☐ Physically independent in community
☐ Requires assistance with transportation to community events/resources but can remain unaccompanied
☐ Requires accompaniment on selected outings
☐ Requires accompaniment on all outings
☐ Does not/cannot participate

Comments (Specify current community inclusive activities and mode of transportation): ____________________

File #: ________________________________

ENVIRONMENTAL ASSESSMENT

Complete this section if the client is living at home or the plan is to return home. If an on-site visit is not possible, necessary information should be obtained from a person knowledgeable about the home.

Provider of Information: ____________________________ Relationship to Client: ____________________

Check the appropriate descriptor if there are problems with the current or prospective home environment.

Household Amenities

☐ Housing (condition)
☐ Household Heating
☐ Cooking Surfaces
☐ Refrigeration
Laundry: ☐ Washing ☐ Drying
Water: ☐ Hot ☐ Cold
☐ Toilet/Plumbing
☐ Smoke Detector (battery/electric)
Other: ______________________________________

Accessibility

Bathroom: ☐ Tub ☐ Shower
☐ Stairs
☐ Telephone
☐ Raised Levels
☐ Electrical Lighting
☐ Floor Surfaces
☐ Indoor Accessibility
☐ Outdoor Accessibility
Other ______________________________________

Comments (Include required environment modifications that may increase the level of independence and/or personal/residential safety): ____
____
____
____
____
____
____
____
____

Safety

☐ Understands all home/public safety rules
☐ Understands all home/public safety rules with reminding and cues
☐ Complies with all home/public safety rules with occasional support
☐ Complies with all home/public safety rules only when continually supervised
☐ Does not understand
☐ Understands/Does not comply

Comments: ____
____
____
____
____
____
____
____
____
____
____

File #: ______________________________

COMMUNITY SERVICE PLAN

	Current	Referral		Current	Referral
Nursing	☐	☐	NL Assoc. for Community Living	☐	☐
Social Work	☐	☐	Canadian Paraplegic Association	☐	☐
Behavior Management Specialist	☐	☐	Independent Living Resource Centre	☐	☐
Physician	☐	☐	Consumer Organization for Disabled	☐	☐
Respiratory Technologist	☐	☐	People First	☐	☐
Occupational Therapist	☐	☐	Employment Counselling	☐	☐
Physiotherapist	☐	☐	NL Hard of Hearing Association	☐	☐
Dietitian	☐	☐	Volunteer Services	☐	☐
Dentist	☐	☐	CNIB	☐	☐
Optometrist/Ophthalmologist	☐	☐	Vera Perlin	☐	☐
Audiology/Speech Language	☐	☐	Meals on Wheels	☐	☐
Psychiatric Rehabilitation	☐	☐	NL Housing	☐	☐
Adult Daycare	☐	☐	Other (specify):	☐	☐
Geriatric Assessment Waterford	☐	☐	______________________________		
Laboratory Services	☐	☐	______________________________		
Home Support Services	☐	☐	______________________________		

Home Support Services

	Current Services		Assessor's Recommendations	
	Hours/day	Days/week	Hours/day	Days/week
Agency				
• Personal Care	________	________	________	________
• Household Management	________	________	________	________
• Respite	________	________	________	________
• Behavioral Aide	________	________	________	________
Private				
• Personal Care	________	________	________	________
• Household Management	________	________	________	________
• Respite				
• Behavioral Aide	________	________	________	________
Total Hours	________	________	________	________

Funding Source	Current Services	Assessor's Recommendations
• Private Insurance	________________	________________
• Veterans Affairs Canada	________________	________________
• Other ________ (Specify)	________________	________________
• RHA	________________	________________

Residential Respite	Numbers per year	Numbers per year
• Daily	________	________
• Weekend		
Regular	________	________
Extended	________	________
• Vacation	________	________

Comments: ____

____

File #: ______________________________

	Name	Address
Home Support Agency	______________	______________
	______________	______________

	Name	Address
Residential Respite Provider	______________	______________
	______________	______________
	______________	______________
	______________	______________
	______________	______________

RESIDENTIAL SERVICE PLAN

Geriatric Assessment

☐ Not Applicable

☐ Yes ☐ No ☐ Referred

Comments: ______________________________

____

____

Facility Based Respite - Personal Care Home/Long Term Care Home

☐ Not Applicable

☐ Yes ☐ No Facility:______________________________

Level of Care Required: ____________ Date: From:______________ To: ____________

Comments: ______________________________

____

____

____

____

____

____

____

____

____

____

____

File #: ______________________________

Long Term Placement

☐ Not Applicable

☐ Personal Care Home
☐ Alternate Family Care
☐ Board/Lodging
☐ Co-op Apartment
☐ Shared Arrangement

☐ Long Term Care Home
 ☐ first available bed policy explained, if applicable
 ☐ internal transfer list explained, if applicable

☐ Other

Level of care required: ______________________________

Preferences:

#1: ______________________________

#2: ______________________________

#3: ______________________________

Comments: ______________________________

File #: ______________________________

SUMMARY AND RECOMMENDATIONS

Descriptors to Consider

- orientation/cognition
- physical assessment
- physical activities of daily living
- instrumental activities of daily living
- behavioral assessment
- mental health assessment
- social assessment
- environmental assessment
- personal hobbies/interests
- equipment (to accompany, or required)
- changes in life circumstances
- perception of needs
- client's strengths
- client's limitations
- current conflict/stress
- other family/caregiver dynamics

Assessor's Signature:______________________________ Profession:______________________________

Telephone Number:______________________________ Date:______________________________

File #: ____________________________________

(Summary and Recommendations Continued)

Assessor's Signature:______________________________ Profession:______________________________________

Telephone Number:________________________________ Date:____

File #: ______________________________

APPENDIX A

BURIAL ARRANGEMENTS

My burial arrangements are pre-arranged: ❑ Yes ❑ No

Person responsible for burial arrangements:

Name: ______________________________

Address: ______________________________ City/Town: ______________________________

Postal Code: ______________________________ Telephone #: ______________________________

Signature (if possible): ______________________________

Place of Burial: ______________________________

Undertaker: ______________________________ Telephone #: ______________________________

The form of payment for burial is: ❑ Government ❑ Private ❑ Pre-paid

If private payment, please complete:

Person responsible for private payment:

Name: ______________________________

Address: ______________________________ City/Town: ______________________________

Postal Code: ______________________________ Telephone #: ______________________________

Comments: ______________________________

____

____

____

____
Client/Substitute Decision Maker (signature)

______________________________ ______________________________
Client/Substitute Decision Maker (please print) Date (y/m/d)

____
Witness (signature)

______________________________ ______________________________
Witness (please print name) Date (y/m/d)

File #: ________________________________

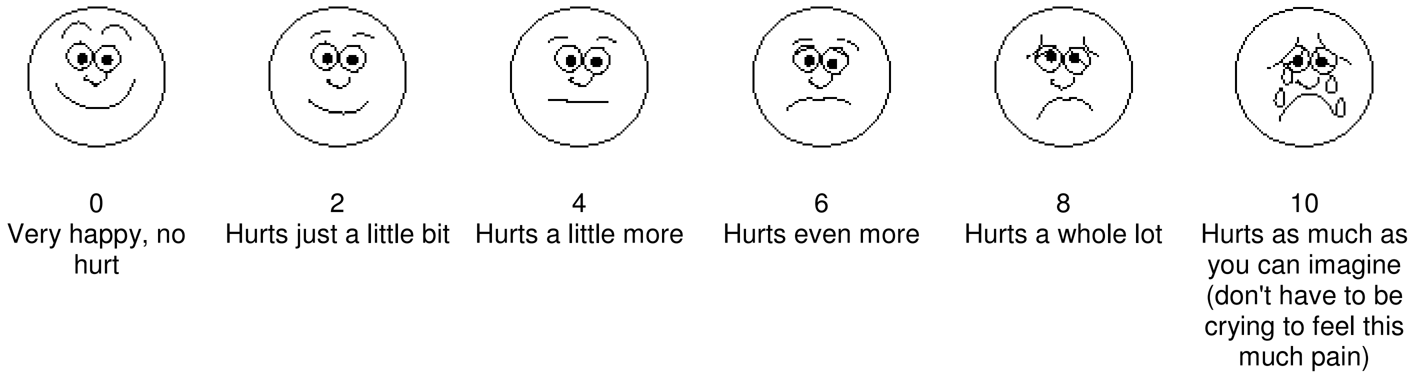
APPENDIX B

Pain Assessment Tools

The Wong-Baker Faces Pain Rating Scale

Designed for children aged 3 years and older, the Wong-Baker Faces Pain Rating Scale is also helpful for people who may be cognitively impaired, the elderly or those with a language barrier. It offers a visual description rather than verbal.

Pain Faces Scale



(Hockenberry M, Wilson D, Winkelstein NL. Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. Used with permission. Copyrighted by Mosby, Inc).

Visual Analog Scale

Directions: Ask the client to indicate on the line where the pain is in relation to the two extremes. Qualification is only approximate; for example, a midpoint mark would indicate that the pain is approximately half of the worst possible pain.

____

no pain   worst pain