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| **Please complete on first session, unless referred from ACAT /DTU /RITH and have access to assessment form** |
| **Client informed consent for assessment and sharing of information:**  **Yes**  **No**  |
| Assessment Date: | Assessor: | Referral source: |
| NOK/Main Contact: | Tel: | Relationship: |
| Usual GP: | GP Tel: | Fax: |
| **Reason for Referral:** | Initial  | Date |
|  |
| Current history /precautions: | Past medical history: |
|  |  |
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|  |  |
| **Social & Domestic Assessment** | Initial  | Date |
| Employment status:**□** | **□** Employed | **□** Unemployed | **□** Retired for age -Pension / Self-funded |
| **□** Retired for disability | Please state previous employment:  |
| Marital status:**□****□** Married | Driving Status: |
| Living arrangements:**□** | **□** Spouse/partner | **□** Relative/friend | **□** Alone  |
| Carer: **□** Yes **□** No Carers Name: Relationship: . |
| Age >70yr: **□** Yes **□** No Carer living-in: **□** Yes **□** No Uses respite: **□** Yes **□** No Employed: **□** Yes **□** No  |
| Carers health: . |
| Frequency of contact with client (inc phone) | **□** Daily  | **□** 1x per wk | **□** 2-3x per wk | **□** Variable  |
| Type of help provided by carer: . |
| Carers perception of major issues: |
|  |
| Advanced Health Directive /EPA /EPG: **□** Yes, please provide details:   | **□** No  |
| Personal Alarm: **□** Yes **□** No  |  DVA: **□** Yes – circle type:*White* /*Gold* **□** No DVA |
| Previous ACAT assessment: **□** Yes - assessment date: / /\_\_\_\_\_ **□** No ACAT **□** TCP  |
| Approval type  | **□** Residential | **□** High Care **□** Low Care  | **□** Residential Respite  | **□** High Care **□** Low Care  | **□** Home Care Packages  | **□** Level 1 + 2 |
| **□** Level 3 + 4 |
| Service provider: | Service type/care provided: |
| Comments  |
| **If any concern, please refer to Social Worker Referral completed:**  **Yes**  **No** |

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| **Current Observations / System Review**  | Initial | Date |
| Pain**□** | **□** No **□** Yes  | Details: |
| Dizziness**□** | **□** No **□** Yes  | Details: |
| Short breath on exertion/rest**□** | **□** No **□** Yes | Details: |
| Visual impairment**□** | **□** No **□** Yes – refer to OT | Details : |
| Glasses**□** | **□** No **□** Yes | Eyes tested in last 2yrs**□□□** No **□** Yes |
| Hearing impairment**□** | **□** No **□** Yes – hearing aids? **□** No **□** Yes | Details: |
| Smoking**□** | **□** Never **□** Quit date: / /\_\_\_\_ Consumption:  |
| Alcohol**□** | **□** Never **□** Quit date: / / Consumption: type: |
| Sleep/rest pattern | Problem falling asleep **□** Yes **□** No  |
|  | Problem staying asleep **□** Yes **□** No |
|  | Sleeping tablets taken? **□** Yes **□** No If *‘yes’* please specify below: |
|  | Type: How often: |
| Comments  |
|  |
| **Medication** | Initial  | Date |
| Administration**□** | **□** Self **□** Supervised **□** Assistance, please specify: |
| Concern expressed about compliance | **□** No **□** Yes |
| Aids/support used**□** | **□** Webster/blister pack **□** Dosette Box **□** Boxes/bottles **□** Timer  |
| 5 or more medications**□** | **□** No **□** Yes |
| Difficulties swallowing medication**□** | **□** No **□** Yes |
| **If any concern, action taken:Advised visit GP****OT referral****SW referral** **discuss in team meeting**  |
| **Communication & Swallowing** | Initial  | Date |
| Do you have any difficulties swallowing food, fluids or medications? e.g. coughing, choking.  | **□** Yes **□** No |
| Have you noticed any changes to your speech/voice? e.g. less clear, more effortful, difficulty thinking of or saying words. | **□** Yes **□** No |
| Are you having difficulty understanding language or writing? e.g. difficulty making sense of a sentence, conversation or written information.  | **□** Yes **□** No |
| **If any concern please refer to Speech Pathologist Referral completed?**  **Yes**  **No** |
| **Mobility** | Initial | Date |
| Transfers **□** | **□** Independent **□** Requires assistance Aids:  |
| Indoor ambulation**□** | **□** Independent **□** Requires assistance Aids:  |
| Outdoor ambulation**□** | **□** Independent **□** Requires assistance Aids:  |
| Stairs**□** | **□** Independent **□** Requires assistance Aids:  |
| **If any concern please refer to Physio Referral completed?**  **Yes**  **No** |

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| **FROP- Com Falls Screen**  | Initial  | Date |
| Falls History | How many falls in last 12months? **□ 0 =** None **□ 1 =** Fall **□ 2 =** 2 Falls **□ 3 =** 3 or more falls | **Score** |
| \_\_\_\_ |
| Function ADL Status | Prior to this fall, how much assistance was required for IADLs?e.g. cooking, housework, laundry **□ 0 =** None, completely independent **□ 1 =** Supervision **□ 2 =** Some assistance **□ 3 =** Completely dependent |  \_\_\_\_ |
| Balance | Observe the client walk a few meters, turn and sit down. Client is to use walking aid if normally used. Score 3 if unable to walk due to injury.**□ 0 =** Steady**□ 1 =** Unsteady but safe**□ 2 =** unsteady, supervision **□ 3 =** Needs hands on assistance |  \_\_\_\_ |
| Screen Score Please circle score total on chart below

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Total Score | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Grading of falls Risk | **0 - 3 Low Risk** | **4 - 9 High Risk** |

**If score of >3, liaise with PT/OT re appropriate action/referral. PT/OT Referral completed? □ Yes □ No** |
| **Home Environment** | Initial | Date |
| Do you have any difficulty getting in/out of the entrances of your home?  | **□** No **□** Yes |
| Do you have any handrails in your home? | **□** No **□** Yes |
| Do you have any difficulty to manage in the shower or toilet? | **□** No **□** Yes |
| Are you having any other difficulties getting on/off bed/chair in your home? | **□** No **□** Yes |
| Comments: |
| **If any concern, please refer to OT Referral completed?**  **Yes**  **No** |
| **Cognition** | Initial  | Date |
| Documented cognitive Impairment? **□** Yes **□** No If *‘yes’* please provide details: |
|  |
| MMSE: / 30 Date: | GDS: Date:  | AMTS: Date:  |
| Recent change in cognitive status? **□** Yes **□** No Self/carer reported cognitive problems? **□** Yes **□** No  |
| Mental health issues, previous/current  |
| **Referral to Memory Clinic completed?**  **Yes**  **No Discussed with GP/consultant?**  **Yes**  **No** |
| **Continence** | Initial  | Date |
| Urinary incontinence  | **□** No **□** Yes | Continence aids used | **□** No **□** Yes details:  |
| Faecal incontinence  | **□** No **□** Yes | Constipation | **□** No **□** Yes |
| Comments |
| **If any concern, please refer to: Nursing coordinator**  **Continence advisor**  **discuss in team meeting**  |



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| **Mini Nutritional Assessment (MNA)** | **Score** |
| **A** Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? 0 = severe loss of appetite 1 = moderate loss of appetite 2 = no loss of appetite |  |
| **B** Weight loss during the last 3 months 0 = weight loss greater than 3 kg (6.6 lbs) 1 = does not know 2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs) 3 = no weight loss |  |
| **C** Mobility 0 = bed or chair bound 1 = able to get out of bed/char but does not go out 2 = goes out |  |
| **D** Has suffered psychological stress or acute disease in the past 3 months? 0 = yes 2 = no |  |
| **E** Neuropsychological problems  0 = severe dementia or depression 1 = mild dementia 2 = no psychological problems |  |
| **F**. Body mass index (BMI)(weight in kg)/(height in m2) 0 = BMI less than 19 1 = BMI 19 to less than 21 2 = BMI 21 to less than 23 3 = BMI 23 or greater |  |
|  **Screening Score** |  **Total**  |
| **12 – 14** Normal – no further action required**8 – 11** At risk of malnutrition – refer to dietitian**0 – 7** Malnourished – refer to dietitian  |  |

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| --- | --- | --- | --- |
| Name | Profession | Signature | Date |
|  |  |  |  |