

Patient Name

Unique #



Draft

Geriatric Outpatient Clinic Assessment Form

Date: Patient Profile: Age: Married Single Widow(er) Divorced

Religion:

Referring Diagnosis

Presenting Issues

Past Medical History

- CVA
 - Hypertension
 - CAD
 - IDDM
 - NIDDM
 - Kidney Disease
 - Hyperlipidemia
 - Cancer
 - Seizures
 - Osteoporosis
 - Osteoarthritis
 - Hypothyroidism
 - Parkinsons Disease
 - Depression
 - COPD
 - Smoker ___ppd x ___yrs.
 - Alcohol Use Quantity _____
- Previous Sx: No Yes

Medications

Medication List (include over the counter medication and herbal remedies)

Medications administered by Self Self but with difficulty Weekly supervision Assisted Other

Uses medication dispenser aid Uses blister pack

Allergies Unknown No Yes → List _____

Name and telephone number of your Pharmacy? _____

Health Care Directives

Have you assigned Power of Attorney for _____ If not, do you want to have more information?

Personal Care No Yes Name: _____ Phone # _____

Property No Yes Name: _____ Phone # _____

Sleep Pattern

- Difficulty falling asleep
- Frequent night time awakening
- Daytime sleepiness
- Amount of sleep during daytime naps _____
- No concerns identified

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Mobility	Have you had any falls in the past year? <input type="checkbox"/> No concerns identified Do you have any difficulty with walking? Do you use any mobility aids? <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> W/C Timed up and Go Score: _____ seconds		
ADL's	<input type="checkbox"/> Difficulty with personal care (i.e. getting dressed, grooming, toileting) <input type="checkbox"/> No concerns identified <input type="checkbox"/> Difficulty with household tasks (i.e. chores, shopping, driving, banking) <input type="checkbox"/> Using any assistive devices? <input type="checkbox"/> Bath Seat <input type="checkbox"/> Grab Bar <input type="checkbox"/> Raised Toilet Seat <input type="checkbox"/> Other _____ <input type="checkbox"/> Are you still driving? _____		
Bowel & Bladder	Urinary continence <input type="checkbox"/> Incontinent of urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urine dribbling/leaking <input type="checkbox"/> Getting up to the bathroom more than once a night		Bowel continence <input type="checkbox"/> No concerns identified <input type="checkbox"/> Incontinent of stool <input type="checkbox"/> Blood in stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea
Psychosocial/ Emotional Status	No	Yes	Comments
			Are you alone during the day?
			What help are you receiving at home? <input type="checkbox"/> Family <input type="checkbox"/> CCAC <input type="checkbox"/> Agency <input type="checkbox"/> Other _____
			Is it enough?
			How are you coping with your present situation? <input type="checkbox"/> No concerns identified How is the caregiver coping? Do you have any financial concerns? Score from Geriatric Depression Scale if indicated _____ Include attachment
Behaviour	<input type="checkbox"/> Appropriate <input type="checkbox"/> Irritable <input type="checkbox"/> Aggressive <input type="checkbox"/> Emotional lability/Apathy <input type="checkbox"/> Other _____ <input type="checkbox"/> No concerns identified		
Cognitive Status	Do you have any problems with your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No concerns identified Abbreviated MMSE Score _____ (Include attachment)		
Nutritional Status	Swallowing <input type="checkbox"/> Normal <input type="checkbox"/> Cough/Choking → Swallowing Assessed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No concerns identified Diet Altered <input type="checkbox"/> No <input type="checkbox"/> Yes → Type: _____ Appetite <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Unplanned weight loss of 10 lb over the past 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No		
Skin	Any problems with your skin? <input type="checkbox"/> No concerns identified		

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Communication	Vision	<input type="checkbox"/> Glasses	<input type="checkbox"/> Magnifying Glass	<input type="checkbox"/> No concerns identified
	Hearing	<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Adequate	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Some Impairment <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deaf	<input type="checkbox"/> No concerns identified
	Language Spoken Primary _____ Secondary _____			
	Expression <input type="checkbox"/> No concerns identified <input type="checkbox"/> Adequate <input type="checkbox"/> Dysarthric <input type="checkbox"/> Word finding difficulties <input type="checkbox"/> Limited Verbal Output			
	Comprehension <input type="checkbox"/> No concerns identified <input type="checkbox"/> Adequate <input type="checkbox"/> Slow to respond <input type="checkbox"/> Partial understanding <input type="checkbox"/> Severely Impaired			

BP Lying:	Pulse	Respirations	Temperature	Height	Weight
Sitting:					

Goals	What main concerns would you like us to address today? How may we help you?
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Plan	Comments
	Suggest referrals to: <input type="checkbox"/> SW <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Dietitian <input type="checkbox"/> SLP <input type="checkbox"/> Pharmacist

Survey	If you were not seen in the Geriatric clinic this week, where else would you have gone for help?	
	Have you been to the Emergency Room or admitted to hospital since last seen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Being followed up in the Geriatric Clinic on discharge from hospital, did you find attending important? Do you wish to have a follow up visit in 30 days time?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide a name and telephone # of the person to be contacted: Contact Name: _____ Daytime Phone # _____

Signature _____

Date _____