Medical Assessment Form

Assessor: ____________________
Date: ___________ Time: ________
Commencement Date ____________
Level: RN LPN PCW CG CS

Personal Information:

Clients Name: ____________________________ Age:_____ Date of birth: _________________

Medical Assessment:

Primary Diagnoses: ____

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Secondary diagnoses: ____

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Relevant medical / surgical information:

Date	Condition	Details of Treatment

Allergies/Sensitivities: ____

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Skin Condition: Intact Redness Decubitus ulcer Excoriation

Diabetic: ______________ Insulin Oral hypoglycemic Diet controlled

Mental Status/Behavior:

Orientation: Time _______ Place_______ Person _______ Comments______________________________

Progressive Disorientation _______________________ Transient Disorientation _______________________

Behaviour: ☐ Compliant to care ☐ Anxious ☐ Restless ☐ Agitated

Aggression: ☐ Verbal ☐ Physical ☐ Sexual

Inappropriateness: ☐ Verbal ☐ Social ☐ Sexual

Abuse: ☐ History of being abused ☐ History of being abusive

Risks: ☐Elopement ☐Falls ☐Aggression ☐Choking

Social/Family/Issues/Concerns: ____

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Functional Status:

Transferring:	Self	Assist	Total care	**Feeding:**	Self	Assist	Total care
Appetite:	Good	Fair	Poor	**Bathing:**	Self	Assist	Bed
Meal Prep:	Self	Assist	Total care	**Appetite:**	Good	Fair	Poor
Housework:	Self	Assist	Total care				

Toiletting: Self Assist Incontinent Bladder Bowel

Notes: ____

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Sensory Perception:

Vision:	Normal	Impaired	Blind	Contacts	Glasses
Hearing:	Normal	Impaired	Deaf	Hearing Aid	
Speech:	Normal	Impaired	Aphasic	Language Spoken ____________	
Literacy:	Literate	Illiterate			
Pain:	None	Acute	Chronic	Location ____________	

Notes: ____

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Activity:

Mobility: Independent Bedridden Assistance Required 1 2

Assistive Devices: Mechanical Lifts Walker Cane Crutches Wheelchair Other ________

Prosthetics Leg Brace Neck Brace Hearing Aid Other ________

Limbs:	Upper Limbs	Normal	Impairment (R / L)	Tremor (R / L)	Amputation (R / L)	Prosthesis
	Lower Limbs	Normal	Impairment (R / L)	Tremor (R / L)	Amputation (R / L)	Prosthesis

Notes: ____

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Nutrition:

Nutritional Status: Height ________ Weight ________ on ________ (date)

Mouth: Own Teeth Partial Dentures (Up / Low) No Teeth Ulcers Infection Drooling

Feeding: Independent Supervision Assistance Total Feed Choking Problem Swallowing Problem

Diet: ____________________ Supplement: ____________________

Notes: ____

____

Elimination:

Bladder: Continent | Incontinent | Nocturia

Indwelling Catheter | Type and Size ____________ | Insertion Date ____________

In & Out Catheterization | Type and Size ____________ | Insertion Date ____________

Ileoconduit | Appliance de to be changed ____________

Condom Drainage

Bowels: Continent | Self Care | Ostomy Care/Ostomy Type ____________

Incontinent | Assist | Date to be changed ____________

Constipation | Total Care | Mushroom Catheter Date Inserted ____________

Diarrhea | C. Difficile | Type and Size ____________

Notes: ____________

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Medications:

Medication	Dosage	Frequency	Comments

Additional Information/Treatments:

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Client or Guardian Authorization

The information contained within this document is not shared with any third parties. The information is kept in the client's home file and the company's client file for as long as services are being rendered. Upon termination of services the document is destroyed in a timely manner or retained if required by law. The document is used as a guide and reference to essential client care information. The Client or Legal Guardian, by signing this document gives the company consent to collect the information contained herein and use for the specified purpose.

Signed ____________ Date ____________