ADMISSION ASSESSMENT AND HISTORY – HOME CARE

Date/Time of Assessment	Place of Assessment ☐ Hospital ☐ Place of Residence

Source of Referral: ☐ Hospital ☐ Physician ☐ Nurse ☐ Family ☐ Other:

Reason for Referral: ☐ Nursing ☐ Meals on Wheels ☐ Homemaking ☐ Personal Care ☐ Other:

Diagnosis:

Procedure and Date:

Allergies: *list and describe reaction(s)* ☐ None Known ☐ Medi Alert on
☐ Facility specific Allergy/Intolerance record completed
☐ Drug:
☐ Food:
☐ Latex:
☐ Environment:

Family Physician:

Language Spoken: ☐ En ☐ Fr ☐ Other:
☐ **Translator required**

Key Contact: *(name, relationship, tel # s)*

Legal Substitute Health Care Decision Maker ☐ Proxy ☐ Personal Guardian ☐ Nearest relative Copy of docs: ☐ Proxy ☐ Personal Guardian
(name, relationship, tel # s)

Financial Power of Attorney: ***(name, tel # s)***

Other contact:

Advance Care Plan (Health Care Directives): ☐ Yes ☐ No ☐ On file Location of form:

DVA#	Treaty#	Blue Cross#	GMS#

	QUESTIONS	YES	NO	PATIENT'S RESPONSE AND INTERVIEWERS COMMENTS
PH	**Personal care assistance**			Bath: ☐ Tub/Shower ☐ Bed ☐ Dressing/Undressing ☐ Oral care Grooming: ☐ Hair ☐ Shave ☐ Make-up ☐ Skin care ☐ Hands ☐ Feet
	Devices			Dentures: ☐ U ☐ L Hearing Aid: ☐ Rt ☐ Lt ☐ Glasses ☐ Contact lenses
ELIM	**Difficulty with bowels** *(describe)*			Date of last BM:
	Difficulty with bladder *(describe)*			
NUTRITION	**Specific Diet**			☐ Reg ☐ Other:
	Assistance required			☐ Meal preparation ☐ Shopping ☐ Feeding
MOBILITY	**Physical limitations** *(walking/stairs, tolerance level)*			☐ One person ☐ Two people ☐ Bedridden ☐ Exercises:
	Devices used			☐ Cane ☐ Walker ☐ Wheelchair ☐ Prosthesis: ☐ Other: TLR Agencies use Mobility Record ☐ See Mobility Record

T	P	R	BP	LMP	SBS	FBS	INR(PT)	Hb	SpO_2	Ht	Wt

OBSERVATIONS AND MEASUREMENTS

Pain ☐Unable to verbalize pain ☐ non-verbal evidence demonstrated by the following symptoms:
Provoked by:

Quality:☐ Sharp ☐ Dull ☐ Stabbing ☐ Burning ☐ Crushing ☐ Intermittent ☐ Occasional ☐ Other:
Radiates/ Location:

Severity: 0 1 2 3 4 5 6 7 8 9 10
Time (when it started, how long it lasts):

Physical assessment *(CNS, CVS, Resp, GI, GUR, MS, Integ, EENT)* ☐ NA ☐ See Assessment Addendum

Pertinent history *(including other medical conditions/surgical/trauma)*

Exposure to:	Yes	No
HIV		
Hepatitis		
TB		
Other:		

History of ARO: ☐ Unknown ☐ No ☐ Yes *(describe)* ☐ VRE ☐ MRSA ☐ TB ☐ Other:

Date of last TB test, results and history:

Date of last influenza immunization: **Date of pneumococcal vaccine:**

☐ Facility specific pressure ulcer risk assessment completed

MED

Current Medications/Herbals: Presently taking meds: ☐ Yes ☐ No ☐ See Best Possible Medication History (BPMH)
Pharmacy of choice: *(Name and Location)*

TX AND PRO

Present treatment(s): ☐ Ostomy care ☐ Trach care ☐ Skin/Wound care ☐ Foot care ☐ Physiotherapy ☐ Chiropractic
(who is doing them?) ☐ O_2 Therapy *(flow rate/freq/method of admin/supplier)*
☐ Other:

Complementary therapies: ☐ Traditional medicines ☐ Other:

TEACHING

Knowledge/skill deficit in:

Teaching required:

SAFETY

Risk for: ☐ Harm to self ☐ Harm to others ☐ Unsafe smoking practices ☐ Wandering
☐ Universal S.A.F.E. Precautions

1. In the past year, have you ever had any fall, including a slip or trip, in which you lost your balance and landed on the floor, ground, or lower level? ☐ Yes ☐ No a. Has medical attention been sought due to a fall? ☐ Yes ☐ No
2. Does the patient have any identifying gait, balance, and/or mobility difficulties? ☐ Yes ☐ No
3. Using clinical judgement, is this patient at risk of falling based on presenting symptoms? ☐ Yes ☐ No
(Consider certain factors such as evolving illness (e.g. emerging delirium, impaired mobility, or new medications being prescribed), unfamiliar surroundings, acquired knowledge, other observations and assessments. If 'yes' to any of the questions, a comprehensive Fall Risk Assessment (e.g. Morse) must be completed along with care plan interventions.) ☐ Facility-specific falls risk assessment completed

Preventive measures being used/needed:

PSYCHOSOCIAL

Family/friends/agencies for:	Yes	No	
support			
transportation			
check on Patient			
bring in supplies			
Home management concerns			☐ Adult Day Program ☐ Lives alone ☐ No telephone ☐ No running water ☐ Laundry ☐ Homemaking ☐ Outside maintenance
Spiritual/Ethnic aspects of care			
clergy visit			☐ Affiliation
Diversional/social activities			☐ Hobbies ☐ Cards/games ☐ Socializing
Substance use alcohol			
tobacco			Would you like information to assist you to quit: ☐ No ☐ Yes
OTC/Rx/Illicit drugs			
other:			

Sleep/rest problems: ☐ No ☐ Yes *(describe)*

☐ Trouble getting to sleep
☐ Frequent waking *(how often)*
☐ Recent changes in sleep pattern
☐ Pain

Sleep Pattern:
Time to bed:
Time waking:
Daytime naps: ☐ AM ☐ PM

Assessment of mental/emotional status: (*mood, thought, behaviour)*

☐ See Assessment Addendum
☐ Facility-specific depression screening completed

Patient's/family's perception of problem(s) and expectations of care:

SERVICES AND EQUIPMENT REQUIRED

☐ Volunteer Services:
☐ Nursing Care:
☐ Personal Care:
☐ Physiotherapy:
☐ Occupational Therapy:
☐ Respiratory Therapy:
☐ Homemaking:
☐ Meals:
☐ Bathing/Toileting Aids:
☐ Medical Aids:
☐ Mobility Aids:
☐ Other:

ADDITIONAL COMMENTS

☐ Risk Assessment completed If yes, name:
☐ Directions to residence: ☐ NA

Date/Time and ID