# INITIAL ASSESSMENT AND HISTORY – LONG TERM CARE

| | |
|---|---|
| **Date/Time of Initial Assessment:** | **Mode of Arrival to Site:** ☐ Walking ☐ Walker ☐ Wheelchair ☐ Stretcher ☐ Other: |
| **Language(s) spoken/understood:** ☐ En ☐ Fr ☐ Other: ☐ Translator required | |
| **Source of Information:** ☐ Pre-Initial Assessment ☐ Self ☐ Family ☐ Other: | **Age:** |
| **Name you wish to be called:** | |
| **Primary Lifetime Occupation:** | **Education:** |
| **Reason for Move-in:** | |

**Key Contact:** Name
Relationship
*Ph #s H:* *W:* *C:*

**Legal Substitute Health Care Decision Maker:**
Name
☐Proxy ☐Personal Guardian ☐Nearest Relative
Copy of documents: ☐ Proxy ☐ Personal Guardian
*Ph #s H:* *W:* *C:*

**Allergies:** *(describe reaction(s))* ☐ None Known ☐ Medi Alert on ☐ Agency Alert on
☐ Site-specific allergy/intolerance record completed
☐ Drug:
☐ Food:
☐ Latex:
☐ Environment:

**Advanced Care Plan (Health Care Directives):** ☐ No ☐ Yes ☐ On file **Location:** _____

**Other contacts:** *(name, relationship, phone #'s)* 1.

2.

Financial Power of Attorney:

| | QUESTIONS | YES | NO | RESIDENT'S RESPONSE AND INTERVIEWER'S COMMENTS |
|---|---|---|---|---|
| PERSONAL HYGIENE | **Personal care assistance** *(help needed, by whom and specific routines)* **bathing** | | | ☐ Tub ☐ Shower ☐ Other: ☐ AM ☐ PM |
| | **grooming** | | | ☐ Foot Care |
| | **oral care** | | | ☐ Mouth pain ☐ Inflamed gums/gingivitis/abscesses ☐ Broken/loose teeth |
| | **dressing** | | | Majority of day spent in: ☐ Street clothes ☐ Bed clothes |
| | **Devices used** *(describe regularity of use, assistance needed)* | | | Dentures: ☐ U ☐ L ☐ Partial ☐ Glasses ☐ Contact Lenses ☐ Magnifying glass<br>Hearing aid(s): ☐ Rt ☐ Lt ☐ present and used ☐ present and not used regularly<br>☐ Other: |
| | **devices with resident** | | | ☐ family to bring ☐ to remain at home |
| ELIMINATION | **Difficulty with bowel care** *(describe)* | | | ☐ Constipation ☐ Diarrhea ☐ Incontinence ☐ Other: Aids: ☐ Pads<br>Bowel Pattern: ☐ daily ☐ EOD ☐ q 3 days ☐ Other: ☐ Liners<br>Bowel continence program: ☐ Briefs/Pull-ups<br>☐ Other:<br>Date of last BM: |
| | **Difficulty with bladder care** *(describe)* | | | ☐ Frequency *(how often)* ☐ Indwelling catheter: *(size/type)* Aids: ☐ Pads<br>☐ Nocturia *(# of times up)* ☐ Liners<br>☐ Incontinence Freq. of change: q ☐ Briefs/Pull-ups<br>Toileting regime: Date of last change: ☐ Other:<br>☐ Intermittent catheter q |
| NUTRITION | **Specific diet** *(specify)* | | | ☐ Regular ☐ Soft ☐ Minced ☐ Pureed ☐ Diabetic ☐ Tube Feed (attach order)<br>☐ Between meal snacks ☐ Other: _____<br>☐ Regular fluids ☐ Nectar thick fluids ☐ Nutritional supplement: *(type & amount)* |
| | **Malnutrition screening** | | | Have you lost weight in the past 6 months without trying to lose this weight? ☐ Yes ☐ No<br>Have you been eating less than usual for more than a week? ☐ Yes ☐ No |
| | **Meal Time Assistance required** *(describe)* | | | ☐ Independent ☐ Minimal assistance ☐ Dependent<br>☐ Special utensils or adaptive equipment needed? _____ |
| | **Eating/drinking difficulty** | | | ☐ Chewing ☐ swallowing ☐ history of choking ☐ other:<br>☐ c/o the taste of food ☐ leaves 25% of meal uneaten ☐ repetitive statements of hunger<br>☐ food left in mouth ☐ dehydrated<br>Do you drink ☐ **more** or ☐ **less** than 1 ½ litres of fluid per day? |
| | **Distinct food preferences** *(specify)* | | | |
| | **Food intolerance** *(specify)* | | | |
| MOBILITY | **Physical limitations** *(describe and include tolerance level)* | | | Dominant hand: ☐ Rt ☐ Lt<br>☐ Bedridden most of time ☐ Able to move independently indoors |
| | **Transferring/lifting assistance required** *(describe)* | | | ☐ Bedrails ☐ Transfer ☐ Mechanical lift ☐ Sask-a-pole<br>☐ Other: |
| | **Turning/positioning required** *(describe program)* | | | |
| | **Assistive devices required** *(list and indicate owner)* | | | ☐ Walker ☐ Wheelchair *(describe)* ☐ Raised toilet seat<br>☐ Brace ☐ wheels self ☐ Prosthesis: *(list)*<br>☐ Crutch ☐ wheeled by other ☐ Orthopedic: *(list)*<br>☐ Cane ☐ Splints ☐ Other: *(list)* |

**TLR Agencies use Mobility Record**

☐ **See Mobility Record**

## OBSERVATIONS AND MEASUREMENTS

| Temp. °C | Pulse ☐ Radial ☐ Apical | Resp/min | BP | Ht cm | Wt kg | $SpO_2$ % | Pedal pulses Rt Lt | Blood Glucose mmol/L |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

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

Standardized pain observation tool: _____
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):

| NORMAL FINDINGS | ABNORMAL SIGNS | HISTORY/CURRENT MEDICAL CONDITIONS | COMMENTS |
|---|---|---|---|
| **CNS** ☐ | ☐ Tremors ☐ Pupils unequal<br>☐ Dizziness ☐ Speech slurred<br>☐ Vertigo ☐ Paraplegia<br>☐ Unsteadiness ☐ Quadriplegia<br>☐ Disoriented ☐ Hemiplegia<br>☐ Memory loss ☐ Hemiparesis<br>☐ Headache ☐ Motor/Sensory loss<br>☐ Other: | ☐ Seizure disorder ☐ Alzheimer's<br>☐ Stroke ☐ Other dementia<br>☐ TIA ☐ Multiple Sclerosis<br>☐ Cerebral palsy ☐ Migraine headaches<br>☐ Parkinson's disease ☐ Headaches<br>☐ Traumatic brain injury ☐ Depression<br>☐ Other: ☐ Panic attacks<br>☐ Diabetic Neuropathy | |
| **CVS** ☐ | ☐ Heart murmur ☐ Arrhythmias<br>☐ Cyanosis ☐ Tachycardia<br>☐ Edema ☐ Bradycardia<br>☐ Other: | ☐ CHF ☐ Rheumatic fever<br>☐ Hypertension ☐ MI<br>☐ Hypotension ☐ Angina<br>☐ Anemia ☐ ASHD<br>☐ Blood disorder ☐ VTE<br>☐ Chest pain ☐ PVD<br>☐ Syncope ☐ Cardiac dysrhythmia<br>☐ Other: | ☐ Pacemaker<br>☐ Implanted cardioverter/ defibrillator |
| **Resp** ☐ | ☐ Shallow ☐ Wheezing<br>☐ Rapid ☐ Cough<br>☐ Slow ☐ SOB<br>☐ Dyspnea ☐ Other: | ☐ Asthma ☐ Frequent URI<br>☐ Pneumonia ☐ COPD<br>☐ Bronchitis ☐ Emphysema<br>☐ Other: ☐ TB | ☐ Chest sounds clear<br>☐ CPAP/BiPAP:<br>☐ Other: |
| **GI** ☐ | ☐ Flatulence ☐ Diarrhea<br>☐ Distension ☐ Nausea<br>☐ Lump ☐ Emesis<br>☐ Obesity ☐ Indigestion<br>☐ Asymmetry ☐ Heartburn<br>☐ Other: ☐ Constipation | ☐ Bulimia ☐ Cholelithiasis<br>☐ Hiatus hernia ☐ Anorexia<br>☐ Umbilical hernia ☐ Ulcer<br>☐ Stomach pain ☐ Hemorrhoids<br>☐ Other pain<br>☐ Other: | ☐ See Elimination for additional information<br>☐ Bowel sounds normal x 4 quadrants<br>☐ Other: |
| **GUR** ☐ | ☐ Discharge ☐ Blood in urine<br>☐ Lesions ☐ Burning<br>☐ Other: | ☐ Cystocele ☐ Kidney problems<br>☐ Rectocele ☐ Renal failure<br>☐ Hysterectomy ☐ Frequent UTI<br>☐ Menstrual problems ☐ Prostate problems<br>☐ Sexually transmitted infection<br>☐ Other: | ☐ See Elimination for additional information<br>LMP *(date)* ☐ NA |
| **Integ** ☐ | ☐ Bruising ☐ Rash ☐ Dry<br>☐ Lesions ☐ Pale ☐ Diaphoretic<br>☐ Abrasions ☐ Flushed ☐ Dehydrated<br>☐ Ulcer ☐ Jaundice ☐ Oily<br>☐ Pruritus ☐ Cyanosis ☐ Lumps<br>☐ Other: | ☐ Psoriasis ☐ Eczema<br>☐ Herpes zoster ☐ Bruises easily<br>☐ Herpes simplex<br>☐ Other: | ☐ See Wound Record |
| **MS** ☐ | ☐ Swelling ☐ Limited ROM<br>☐ Deformities ☐ Spasms<br>☐ Weakness/Atrophy ☐ Amputation(s)<br>☐ Other: | ☐ Rheumatoid arthritis ☐ Osteoporosis<br>☐ Osteoarthritis ☐ Scoliosis<br>☐ Gout ☐ Back problems/pain<br>☐ Pathological fracture:<br>☐ Hip fracture *(last 6 months)*: ☐ Rt ☐ Lt<br>☐ Other fracture *(last 6 months)*:<br>☐ Pain: ☐ hip ☐ joint ☐ soft tissue ☐ bone<br>☐ Other: | ☐ See Mobility Record for additional information |
| **EENT** ☐ | ☐ Deafness ☐ Facial paralysis<br>☐ Hoarseness ☐ Aphasia<br>☐ Blurred vision ☐ Dysphasia<br>☐ Nystagmus ☐ Discharge<br>☐ Other: ☐ Conjunctivitis<br>☐ Tracheostomy | ☐ Diabetic retinopathy ☐ Hearing problems<br>☐ Macular degeneration ☐ Sinusitis<br>☐ Glaucoma ☐ Tinnitus<br>☐ Cataracts<br>☐ Other: | |
| **ENDO** ☐ | ☐ Exopthalmia ☐ Polydipsia<br>☐ Enlarged tongue ☐ Polyphagia<br>☐ Goiter ☐ Polyuria<br>☐ Glucosuria<br>☐ Other: | ☐ Diabetes Mellitus Type 1 ☐ Hyperthyroidism<br>☐ Diabetes Mellitus Type 2 ☐ Hypothyroidism<br>☐ Other: | |

# INITIAL ASSESSMENT AND HISTORY – LONG TERM CARE

## OBSERVATIONS AND MEASUREMENTS

| Examinations: | Date | By who | Where |
|---|---|---|---|
| Medical/Physical | | | |
| Eye | | | |
| Dental | | | |
| Hearing | | | |

| Exposure to: | Yes | No | Comments |
|---|---|---|---|
| HIV | | | |
| Hepatitis | | | |
| TB | | | |
| Other: | | | |

☐ **Site-specific ARO screening tool completed** (if completed, then this section can be omitted)
**Treated for Antibiotic Resistant Organisms (ARO(s))** ☐ No ☐ Not known ☐ Yes: (describe) ☐ VRE ☐ MRSA ☐ Other:

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

**Date of last TB test and results:**

**Date of last hospitalization:** Where: Why:

☐ **Site-specific pressure ulcer risk assessment completed**

**Resident's description of present condition:** *including pain and fatigue*

**History pertinent to this move-in:** *medical, surgical, trauma*

## MEDS

**Presently taking medications:** ☐ Yes ☐ No ☐ See Best Possible Medication History (BPMH)
**Pharmacy of choice**: *(Name and Location)*

| IV/Parenteral therapy *(describe)* | Yes | No | |
|---|---|---|---|
| | | | |

## TXS AND PRO

| | | | |
|---|---|---|---|
| **Previous blood transfusions** *(describe when, why)* | | | |
| **adverse reactions** | | | |
| **Presently receiving any treatments(s)** *(describe, including discipline(s) providing care)* | | | ☐ $O_2$ ☐ Ostomy care ☐ Trach Care ☐ Ventilator ☐ ROM<br>☐ Skin/Wound care: *(specify)*<br>☐ Foot care: *(specify)*<br>☐ Other:<br>☐ Complementary therapies: *(list)* |

**Therapies**
☐ Physiotherapy
☐ Occupational therapy
☐ Respiratory therapy
☐ Recreational therapy
☐ Chiropractic
☐ Other:

## TE

**Assessment of resident/family understanding of move-in and related learning needs**

## SAFETY

**Safety concerns** ☐ 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, SCOTT) must be completed along with care plan interventions.) ☐ Facility-specific falls risk assessment completed

Prevention measures in place: ☐ Hip protectors ☐ Non-skid socks ☐ Wheelchair seatbelts ☐ Other:

History of wandering : ☐ Yes ☐ No ☐ Past month ☐ Other:

**Use of restraints** *(describe)*: ☐ Physical ☐ Environmental ☐ Chemical

**Other:**

## PSYCHOLOGICAL

| | Yes | No | |
|---|---|---|---|
| **Personal/home/work concerns** | | | ☐ Lives alone, in own home ☐ With spouse/family ☐ Assistive living<br>☐ Attends Day Program ☐ Home Care |
| **Significant others for support**: | | | |
| **Involvement of significant other(s)** | | | ☐ Family activities ☐ Transportation ☐ Financial ☐ Daily animal companion/presence<br>☐ Other: *(describe)* |
| **Meaningful relationship concerns** | | | ☐ No contact c̄ family/friends ☐ Daily contact c̄ family/friends ☐ Weekly contact c̄ family/friends<br>☐ Recent loss of close member of family/friend<br>☐ Other: |
| **Ethnic/Educational aspects that affect care** | | | |

| | | | |
|---|---|---|---|
| **Spiritual aspects that affect care** *(describe)* | | | ☐ Finds strength in faith ☐ Enjoys spiritual/religious activities |
| **Clergy visit** | | | Affiliation:<br>Attendance at religious services: ☐ Regular ☐ Irregular ☐ Never |
| **Social/Diversional/Leisure activities** *(past and present)* | | | ☐ Reading/writing ☐ Watching TV ☐ Music ☐ Arts and crafts ☐ Cards and games<br>☐ Gardening ☐ Exercise/sports ☐ Talking/conversing ☐ Helping others ☐ Shopping/trips<br>☐ Hobbies: *(list)* |
| **activity preferences** | | | ☐ Time alone ☐ Group activities ☐ Fixed routine ☐ Goes out 1x/wk |
| **activity location preferred** | | | ☐ Own room ☐ Dayroom/activity room ☐ Onsite ☐ Offsite |
| **Use of tobacco** *(describe assistance required)* | | | ☐ Smoking policy explained.<br>Would you like assistance to quit? ☐ Yes ☐No ☐ Not Applicable |
| **Substance use** *(describe what, when, amount, any previous or present treatment)* | | | ☐ Alcohol<br>☐ Inhalants: *(list)*<br>☐ Illicit drugs: *(list)*<br>☐ Other: |
| **Difficulty sleeping** *(why and what helps?)* | | | ☐ Trouble getting to sleep<br>☐ Frequent waking *(how often)*<br>☐ Recent changes in sleep pattern<br>☐ Other:<br>Sleep pattern:<br>Time to bed:<br>Time waking:<br>Daytime naps: ☐ AM ☐ PM |

**PSYCHOLOGICAL**

**ASSESSMENT OF MENTAL, EMOTIONAL, BEHAVIOURAL AND PSYCHIATRIC STATUS**

| NORMAL FINDINGS | ABNORMAL SIGNS | | | HISTORY | COMMENTS |
|---|---|---|---|---|---|
| **General Appearance** ☐ | ☐ Slumped posture<br>☐ Inappropriate dress<br>☐ Other: | ☐ Mannerisms<br>☐ Tic | ☐ Unkempt<br>☐ Gestures<br>☐ Crying/tearful | | |
| **Behaviour** ☐ | ☐ Restlessness<br>☐ Aggression<br>☐ Argumentative<br>☐ Agitation<br>☐ Repetitive movements<br>☐ Other: | ☐ Impulsive<br>☐ Intimidating<br>☐ Hyperactive<br>☐ Lethargic<br>☐ Passive | ☐ Verbally abusive<br>☐ Physically abusive<br>☐ Socially inappropriate<br>☐ Disruptive<br>☐ Resisting care<br>☐ Wandering | ☐ Bipolar illness | ☐ Difficulty adjusting to change in routine |
| **Communication** ☐ | ☐ Mutism/No speech<br>☐ Aphasia<br>☐ Slurred speech<br>☐ Loquaciousness<br>☐ Loose associations<br>☐ Other: | ☐ Hesitancy<br>☐ Echolalia<br>☐ Incoherent<br>☐ Neologisms<br>☐ Flight of ideas<br>☐ Repetitive vocalizations | ☐ Word salad<br>☐ Rumination<br>☐ Perseveration<br>☐ Confabulation<br>☐ Tangential speech | ☐ Autism | Modes ☐ Written messages<br>☐ Sign Language<br>☐ Braille<br>☐ Signs/Gestures<br>☐ Lip reading<br>☐ Communication board<br>☐ Other |
| **Thought Process** ☐ | ☐ Confusion<br>☐ Hallucinations<br>☐ Mental function variable throughout day<br>☐ Other: | ☐ Delusional<br>☐ Obsessional | ☐ Suspicious<br>☐ Slow associations | ☐ Schizophrenia<br>☐ Mentally challenged<br>☐ Developmental Disability/Delay | ☐ Delirium risk assessment completed |
| **Emotional State** ☐ | ☐ Flat affect<br>☐ Anxious<br>☐ Other: | ☐ Depressed<br>☐ Grandiosity | ☐ Pervasive elation<br>☐ Euphoric<br>☐ Labile | ☐ Anxiety disorder<br>☐ Depression | |
| **Orientation Concentration Alertness** ☐ | ☐ Lack of judgement<br>☐ Short term memory loss<br>☐ Long term memory loss | ☐ ↓ LOC<br>☐ Easily distracted<br>☐ No insight | Disoriented to:<br>☐Person<br>☐ Place | | |

☐ See Notes

**Appointments scheduled prior to this move-in:**

☐ Funeral Home Chosen *(name, location)*

| **Orientation to unit** | **Yes** | **No** |
|---|---|---|
| Physical Layout | | |
| Daily Routine | | |
| If No, why not: | | |

**Belongings** ☐ Site-specific resident belongings form *(if completed, then this section can be omitted).*

| | **At bedside** | **Locked up** | **Labeled** | **Sent home** | **Other:** |
|---|---|---|---|---|---|
| Clothing | | | | | |
| Furniture | | | | | |
| Valuables | | | | | |
| Other | | | | | |

**Date/Time:**

**ID**