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| **Comprehensive Geriatric Assessment** |
| **Assessment Date**: | **Accompanied By**: |
| **Primary Contact Person**: | **Phone Number**:**Phone Number (alt)**: |
| **General Practitioner**: | **Consent:** |
| **Referral** |
| **Referral Source**:**Referral Date**: **Reason for Referral**: **AUA Score:** |
| **Patient Expectations**:**Caregiver Expectations**: |
| **Social History** |
| **Place of Birth**: | **First Language**:**Other Languages Spoken**:**Language spoken daily at home**: |
| **Education**: | **Handedness**: |
| **Past/Current Occupations**: |
| **Marital Status and Duration**: |
| **Living Arrangements (i.e. alone, spouse, institution)**:**Type of Dwelling (i.e. house, apartment, single storey)**: |
| **Children**:**Number of Children**: **Local Supports**: **Contact with Patient**: |
| **Power of Attorney**:**Name**: | **Financial**:**Personal Care**: |
| **Eligible Veteran (Overseas service for more than 1 year)**:**Other Private Insurance Coverage**: |
| **History of functional decline** |
| **Describe the change in function (i.e. when and why did the change occur) and trajectory (i.e. steep, gradual, peaks****and valleys, gradual descending plateaus, etc.) of functional decline:****Risk factors for functional decline:**Cognitive impairment Low level of social contacts Depression low level of physical activity High disease burden Polypharmacy |

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| High or low BMI Poor self-perceived healthLE functional limitation SmokingVisual impairment Other: |
| **Functional Status****(I=independent, AP=assistance due to physical limitation, AC=assistance due to cognitive limitation, DP=dependent due to physical limitation, DC=dependent due to cognitive limitation, N/A=never completed by client in the past)** |
| **Activities of Daily Living** |
|  | **Current Status** | **Previous Status** |
| **Transferring** |  |  |
| **Toileting** |  |  |
| **Continence** |  |  |
| **Eating** |  |  |
| **Mobility** |  |  |
| **Bathing** |  |  |
| **Dressing** |  |  |
| **Grooming** |  |  |
| **Instrumental Activities of Daily Living** |
|  | **Current Status** | **Previous Status** |
| **Using phone** |  |  |
| **Grocery****Shopping** |  |  |
| **Meal****Preparation** |  |  |
| **Laundry** |  |  |
| **Housekeeping** |  |  |
| **Medication** |  |  |
| **Finances** |  |  |
| **Transportation** |  |  |
| **Formal and****Informal****Supports** |  |  |
| **Current****Hobbies** |  |  |
| **Exercise** |  |  |
| **Cognition** |
| *(i.e. ST vs. LT memory, word finding difficulties, disorientation, decreased ability to perform motor task or to multitask)* ***and history******of onset*** *(i.e. gradual, abrupt)* ***and progression*** *(i.e. smooth, fluctuating, stepwise)* ***of cognitive impairment:*** |

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| **Current Symptoms**:**Decreased short term memory**:**Repetitiveness**:**Word finding difficulty**:**Decreased recognition of faces/people**: **Disoriented in new places/getting lost**: **Decreased ability to Multitask**:**Decreased ability to perform motor tasks**: |
| **Summary of Cognitive Testing**:**SMMSE**:**Clock Drawing**:**Semantic Fluency**: **Phonemic Fluency (FAS)**: **MoCA**:**Trails A**:**Trails B**: |
| **Mood** |
| **Past history of depression and any past treatment/institutionalizations**:**Currently, do you often feel sad or depressed**?**Details recent/current regarding onset, progression and symptoms**:**Has the patient experienced paranoia, delusions, hallucinations, or agitation/aggression?** |
| **SIGECAPS** *(completed if mood concerns identified above)***:****Sleep**: **Interests**: **Guilt**: **Energy**:**Concentration**:**Appetite**:**Psychomotor slowing/Agitation**:**Suicide: Active**: **Passive**:**Total Positive SIGECAPS:** |
| **Summary of Mood Screens** *(completed if total positive SIGECAPS yields ≥2)***:****GDS**: **Cornell**: **BDI:** |
| **Sleep** |
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| **Nutrition** |
| **Have you lost any weight within the last 6 months**? |
| **Pain** |
| ***Include history of onset, affected areas, PQRST, effect on activity, treatments/medications:*** |
| **Falls/Dizziness** |
| **Have you had any falls**?**Patient Risk Factors**:Polypharmacy Sedative use Uses mobility aid Weakness MSK conditions Vision impairment Hearing impairment Cognitive impairment Risk factors in homeenvironmentNutritional concerns Postural hypotension Incontinence |
|  |  | Other: |
| **Continence** |
| **Bladder** |
| **Urinary Incontinence**:**Urgency**: **Hematuria**: **Stress**: **Frequency**: **UTIs**: **Nocturia**: |
| **Bowel** |
| **Fecal Incontinence**:**Constipation**:**Diarrhea**:**GI Bleed**:**Bowel Routine**: |
| **Past Medical/Surgical History** |
| **Allergies: Hearing**: **Vision**:**Seizures/head injuries**: |
| **Have you had any Emergency Department visits in the last year**?**Have you had any hospitalizations in the last year**? |

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| **Smoking History**: |
| **Alcohol History**: |
| **Family History:****Parents**: **Siblings**: **Children**: |
| **Medication *\*include OTC meds/ herbs/ vitamins/ etc.*** |
| **Pharmacy**:**How are medications taken (i.e. reminders, blister pack)**?**Allergies to medications**: |
| **Medication** | **Dose/Frequency** | **Start Date** | **Stop Date** | **Ordered By** | **Pill Count** | **Comments** |
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| **Clinical Frailty Score:** |
| **Recommendations** |
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**Assessment Urgency Algorithm (AUA tool)**



Assessor Signature: Date: