

# Manitoba Home Care Program CARE ASSESSMENT FORM



Applicant's Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_ PHIN No. \_\_\_\_\_

TYPE OF ASSESSMENT       Admission       Reassessment      Coordinator \_\_\_\_\_

Location where assessment completed (own house, hospital, etc.)      Office Location \_\_\_\_\_

## FAMILY INFORMATION/FUNCTIONAL ASSESSMENT

1. Who lives in same household with applicant? (If none write "none" in space.)

Name	Age	Relationship	REMARKS: (Indicate if supportive of applicant and how.)

2. List relevant family members. (If none, write "none" in space.)

Please check ( ✓ ) next of Kin or local person responsible.

Please check ( ✓ )

REMARKS: (Indicate distance, frequency of contact, supportiveness of applicant and how.)

Name	
Address	
Name	
Address	
Name	
Address	
Name	
Address	

3. Any additional information/assessment re: family functioning pertinent to assessment for/delivery of home care:

## HOUSEHOLD INFORMATION/FUNCTIONAL ASSESSMENT

4. APPLICANT LIVES IN \_\_\_\_ House \_\_\_\_ Rooms \_\_\_\_ Apartment \_\_\_\_ Senior Citizen Housing \_\_\_\_ Family Care/Foster Home  
 \_\_\_\_ Other (specify) \_\_\_\_\_ REMARKS: \_\_\_\_\_

5. INDICATE FACILITIES AVAILABLE AND ADEQUACY

	Available (type)	Adequacy (yes, no, if no explain)
HEATING		
COOKING		
REFRIGERATION		
LAUNDRY		
DRYING		
WATER		
TOILET		
BATHING		
STAIRS		
TELEPHONE		

6. Indicate if any of the above facilities (including their location) affect the ability of the applicant to function in home or to get outside:

7. Indicate if any of the above facilities (including their location) will affect the need for and delivery of services in the home:

8. HOUSEHOLD TASKS/MANAGEMENT

	Formerly Done By Applicant Yes/No	Still Done Yes/No	REMARKS: Where still done indicate any limitations, also where not done but if formerly done indicate why not done and specify who (if anyone) now does it.
LIGHT CLEANING			
HEAVY CLEANING			
PERSONAL LAUNDRY			
HOUSEHOLD LAUNDRY			
SHOPPING			
FULL MEAL PREPARATION			
LIGHT MEAL PREPARATION			
USE PHONE			
MANAGEMENT OF OWN AFFAIRS			

9. Any additional information/assessment re: household functioning pertinent to the assessment for/delivery of home care:

HEALTH INFORMATION/HEALTH FUNCTIONAL ASSESSMENT

10. MAJOR CLINICAL FINDINGS: (Do not repeat if on basic information sheet.)

Diagnosis/Extent of Disability:

Diagnosis Known:

To Family  Yes  No  
To Applicant  Yes  No

11. CLINICAL HISTORY:

12. ALLERGIES: if any, describe

13. Medication	Dosage	Frequency	Route	Prescribed By	Date

Ability to Administer:  Independent  Requires Assistance Specify

Compliance:

14. Current prescribed treatments, if any: Indicate applicant's ability to manage own treatment.

Independent  Requires Assistance Specify

15. Have clinical findings/treatment been confirmed with attending physician?

Yes  No

If Yes, how. If No, what is the plan for confirmation?

16. NUTRITION: Is applicant eating adequately:  Yes  No  
Is applicant on special diet?  Yes  No

COMMENTS:

17. Any additional information/assessment re: physical health functioning pertinent to the assessment for/delivery of home care:

**PERSONAL CARE INFORMATION/FUNCTIONAL ASSESSMENT**

**REMARKS:**    **Should reveal any patterns/inconsistencies.**  
**Should include any current or planned treatment/intervention.**  
**Should cover implications for self care, for socialization.**

<p>18. SIGHT:</p> <p><input type="checkbox"/> Wears glasses                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><input type="checkbox"/> Adequate for all activities</p> <p><input type="checkbox"/> Inadequate for some activities (specify)</p> <p><input type="checkbox"/> Inadequate for personal safety (specify)</p>	<p>REMARKS:</p>																
<p>19. HEARING</p> <p><input type="checkbox"/> Wears hearing aid                      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><input type="checkbox"/> Adequate for all activities</p> <p><input type="checkbox"/> Inadequate for some activities (specify)</p> <p><input type="checkbox"/> Inadequate for personal safety (specify)</p>	<p>REMARKS:</p>																
<p>20. COMMUNICATION:</p> <p><input type="checkbox"/> Gestures Only                      <input type="checkbox"/> Written Only</p> <p><input type="checkbox"/> Adequate for all activities</p> <p><input type="checkbox"/> Inadequate for some activities (specify)</p> <p><input type="checkbox"/> Unable to communicate</p>	<p>REMARKS:</p>																
<p>21. AMBULATION:</p> <p><input type="checkbox"/> Independent with or without mechanical aid</p> <p><input type="checkbox"/> Outdoors with assistance</p> <p><input type="checkbox"/> Indoors ambulation with assistance</p> <p><input type="checkbox"/> Stairs with assistance</p> <p><input type="checkbox"/> Stairs independent</p> <p><input type="checkbox"/> Cannot manage stairs</p> <p><input type="checkbox"/> Wheelchair independent</p> <p><input type="checkbox"/> Wheelchair with assistance</p>	<p>REMARKS:</p>																
<p>22. TOILETING:</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><b>CONTINENCE</b></td> <td style="width:50%; border: none;"><b>MANAGEMENT</b></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Completely continent</td> <td style="border: none;"><input type="checkbox"/> Independent</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Incontinent urine, occasionally</td> <td style="border: none;"><input type="checkbox"/> Dependent (elaborate)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Incontinent urine, night only</td> <td style="border: none;"><input type="checkbox"/> Catheter</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Incontinent urine, always</td> <td style="border: none;"><input type="checkbox"/> Ostomy</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Incontinent feces, occasionally</td> <td style="border: none;"><input type="checkbox"/> Condom Drainage</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Incontinent feces, always</td> <td style="border: none;"><input type="checkbox"/> Bathroom Routine</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other Aids</td> </tr> </table>	<b>CONTINENCE</b>	<b>MANAGEMENT</b>	<input type="checkbox"/> Completely continent	<input type="checkbox"/> Independent	<input type="checkbox"/> Incontinent urine, occasionally	<input type="checkbox"/> Dependent (elaborate)	<input type="checkbox"/> Incontinent urine, night only	<input type="checkbox"/> Catheter	<input type="checkbox"/> Incontinent urine, always	<input type="checkbox"/> Ostomy	<input type="checkbox"/> Incontinent feces, occasionally	<input type="checkbox"/> Condom Drainage	<input type="checkbox"/> Incontinent feces, always	<input type="checkbox"/> Bathroom Routine		<input type="checkbox"/> Other Aids	<p>REMARKS:</p>
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<p>23. TRANSFERRING:</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Bed to chair with assistance</p> <p><input type="checkbox"/> Bedfast, can turn self in bed</p> <p><input type="checkbox"/> Bedfast, must be turned in bed</p>	<p>REMARKS:</p>
<p>24. EATING:</p> <p style="padding-left: 40px;">Dentures:      <input type="checkbox"/> Upper   <input type="checkbox"/> Lower</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Requires assistance or encouragement</p> <p><input type="checkbox"/> Has to be fed</p>	<p>REMARKS:</p>
<p>25. DRESSING:</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Requires assistance or encouragement</p> <p><input type="checkbox"/> Has to be dressed/undressed</p>	<p>REMARKS:</p>
<p>26. BATHING:</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Can sponge bath self</p> <p><input type="checkbox"/> Can bath only with assistance or encouragement</p> <p><input type="checkbox"/> Has to be bathed</p>	<p>REMARKS:</p>
<p>27. CARE OF HAIR:</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Requires assistance or encouragement</p> <p><input type="checkbox"/> Cannot care for own hair</p>	<p>REMARKS:</p>
<p>28. FOOT CARE:</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Requires Assistance</p> <p><input type="checkbox"/> Cannot care for own feet</p>	<p>REMARKS:</p>

29. CARE FOR PROTHESIS:

Where applicable, indicate type of prosthesis and ability of applicant to care for such.

Any additional information/assessment re: personal care functioning pertinent to the assessment for/delivery of home care:

**PSYCHO/SOCIAL INFORMATION/FUNCTIONAL ASSESSMENT**

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30. Has applicant's living pattern/role in family or household altered in past year? Describe showing whether there has been change or loss and indicate whether (how) applicant is coping. Look for indicators of loneliness, bereavement or loss of status.

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31. Describe how applicant spends his/her time in a typical day at home and indicate if applicant describes his/her activities as being meaningful to others, to self or simply as a means of passing time.

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32. Are there any activities which the applicant formerly was engaged in at home which he/she now misses? Why? Could the applicant be involved again in the same or similar activity with assistance/intervention? What?

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33. Neighbours, friends in contact with applicant:		REMARKS: (Indicate frequency of contact and supportiveness to applicant and in what way.)
Name Address	Phone #	
Name Address	Phone #	
Name Address	Phone #	
Name Address	Phone #	

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34. Describe applicant's involvement in community (include church, legion, fraternal, etc.)

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35. Are there any community activities in which the applicant formerly was involved which he/she now misses? Could the applicant be involved again with assistance/intervention? What?

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36. Does travel outside the home affect applicant's ability to participate in activities, to receive medical care, to manage the household, etc.? If so, describe why, how and intervention indicated.

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37. Specify cultural/religious preferences of applicant relevant to delivery of home care services (language, special food, etc.)

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**REMARKS: Should reveal any patterns/inconsistencies.  
Should include any current or planned treatment/intervention.  
Should cover implications for self care, for socialization.**

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38. MENTAL STATUS:

- Completely oriented
- Forgetful/confused occ.
- Disoriented

REMARKS:

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39. MOOD:

- Seems content
- Seems concerned about specific problem
- Seems somewhat tense and anxious
- Seems depressed
- Unusual, unpredictable behavior (specify)
- Not motivated for some activities (specify)

REMARKS:

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40. MOTIVATION:

- Motivated for all activities
- Not motivated for some activities (specify)
- Not motivated for most activities

REMARKS:

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41. JUDGEMENT IN PRESENT SITUATION:

- Realistic
- Adequate for personal safety
- Limited ability to make judgements
- Unrealistic

REMARKS:

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42. Any additional information/assessment re: psycho/social functioning pertinent to assessment for/delivery of home care:

## SUMMARY ASSESSMENT

Under the following headings indicate the area(s) (if any) where the applicant cannot meet need through self-functioning or through the services of available family or others, and which, if the need is not met, places the applicant at risk of no being able to remain in the community-or-places the applicant at risk of deterioration which could directly contribute toward inability to remain in the community.

Where the applicant's ability to remain in the community is dependent upon the service of others in the household or in the community, show where the relief of such providers is realistically indicated for continued living in the community.

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HOUSEHOLD MAINTENANCE NEEDS

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HEALTH NEEDS

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PERSONAL CARE NEEDS

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PSYCHO/SOCIAL NEEDS

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SUPPLIES/EQUIPMENT NEEDS