

PROFESSIONAL CARE MANAGEMENT ASSESSMENT

Date _____ Client's Name _____ S.S. # _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____

Referral Source _____

Assess Start Date _____ Care Manager _____

Persons attending assessment & persons contributing through consultation:

(relationship)

(relationship)

(relationship)

Reason for Referral:

I. Medical History:

Doctor's name	Doctor's office phone number

Diagnoses

(onset date)

Medications

Name **Amount** **Frequency** **Route** **Rx#** **Who Prescribed**

Name	Amount	Frequency	Route	Rx#	Who Prescribed

Pharmacy _____ **Phone** _____

Hours of Pharmacy _____

Allergies	Reactions

II. Client Functioning – Physical (ADLs, reported complaints), Mental (orientation, memory capacity):

Previous functional abilities (any recent changes)

Present functional abilities – Physical

Present functional abilities – Cognitive/Psychological

ADL:	Self	Supervision	Assistance (& who provides it)
Dressing			
Eating			
Ambulating			
Gets in/out of bed			
Toileting			
Hygiene (bathing, shaving, etc.)			

IADL	Self	Supervision	Assistance (& who provides it)
Shopping			
Housework			
Food Preparation			
Transportation			
Medications Set-up			
Home Maintenance			
Money Management			
Telephoning			
Laundry			

Nutrition

- | | |
|--|------------|
| | YES |
| 1. I have an illness/condition that made me change the kind &/or amount of food I eat. | _____ |
| 2. I eat fewer than 2 meals per day. | _____ |
| 3. I eat few fruits or vegetables, or milk products. | _____ |
| 4. I have 3 or more drinks of beer, liquor or wine almost every day.* | _____ |
| 5. I have tooth or mouth problems that make it hard for me to eat. | _____ |
| 6. I don't always have enough money to buy the food I need. | _____ |
| 7. I eat alone most of the time. | _____ |
| 8. I take 3 or more different prescribed or over-the-counter drugs a day. | _____ |
| 9. Without wanting to, I have lost or gained 10 pounds in the last 6 months. | _____ |
| 10. I am not always physically able to shop, cook and/or feed myself. | _____ |

Total: _____

Nutritional Score. If it's...

0-2, Good! 3-5, Moderate nutritional risk 6+, High nutritional risk

Weight stated _____ Observed (if different from stated) _____

Notes re: Nutrition

Daily Routine (Tell me about your day)

Hours of sleep _____

***Alcoholism: (CAGE)**

- | | | |
|--------------------|---|-----|
| <i>Cut Down</i> | Have you tried to cut down on your drinking? | Y N |
| Annoyed or angered | Have others annoyed/angered you by criticizing your drinking? | Y N |
| <i>Guilty</i> | Have you ever felt guilty about your drinking? | Y N |
| <i>Eye-opener</i> | Have you used alcohol to steady your nerves... | Y N |
| | Or, to reduce the effects of a hangover? | Y N |
| | Amount/How much? _____ | |

Family observations re: nutrition/substance use	Y N
Suicidal Ideation	Y N
Recently, have you been feeling like you just don't want to go on anymore?	Y N
Who do you talk to when you are feeling low or depressed?	Y N
Have you ever thought of suicide?	Y N
Have you ever attempted suicide?	Y N
If yes, how would or how did you do it?	Y N
Have you noticed your elder talking about suicide?	Y N
Has your elder been giving away personal items or purposefully saying goodbye?	Y N

III. **Home Environment:** *Own Rent Home Apartment Other* _____

For how long? (recent changes?) _____

Persons living in household _____ **Ability/willingness to help client?** _____

Environmental assessment

Does the patient use assistive devices (walkers, canes) correctly?	Y N
Are they the right height?	Y N
Do the devices fit through the pathways without catching on furnishings?	Y N
Are the pathways, hallways, and stairways clear?	Y N
Are there throw rugs?	Y N
Are there sturdy handrails on the stairs?	Y N
Are the first and last steps clearly marked?	Y N
Is there adequate lighting in hallways and stairways?	Y N
Is the path to the bathroom well-lighted at night?	Y N
Are the floors slippery?	Y N
(Floors should not have a high gloss or be highly waxed)	
Are there uneven floor surfaces?	Y N
Are the carpets in good repair without buckles or tears that would cause tripping?	Y N
Can the client walk steadily on the carpets?	Y N
(Thick pile carpets can cause tripping if the patient has a shuffling gait.)	
Are the chairs the client uses sturdy?	Y N
Are they stable if the client uses them to prevent a fall?	Y N
Does the client use furniture or counters for balance when walking?	Y N
Are these sturdy enough to withstand the pressure?	Y N
Are there cords or wires that could cause the client to trip?	Y N

Fire/Burn Prevention

Is there a smoke detector on each level of the home?	Y N
Is there a fire extinguisher?	Y N
Is there an escape plan for the patient to get out of the house in case of fire?	Y N
Is the client using heating pads and space heaters safely?	Y N
Are wires and plugs in good repair?	Y N

If the client smokes, are there plans to make sure the patient smokes safely?	Y	N
Are there signs of cigarette burns?	Y	N
Are there signs of burns in the kitchen?	Y	N
Are oxygen tanks stored away from flames and heat sources?	Y	N

Crime/Injury Prevention

Are there locks on the doors and the windows?	Y	N
Can the client make an emergency call?	Y	N
Is the telephone handy?	Y	N
Are emergency numbers clearly marked?	Y	N
Are firearms securely stored in a locked box?	Y	N
Is the ammunition stored and locked away separately?	Y	N
Is there evidence of criminal activity?	Y	N

Communication

Is the telephone within easy reach of the client?	Y	N
Should the telephone have an illuminated dial?	Y	N
Oversized numbers?	Y	N
Memory feature?	Y	N
Audio enhancer?	Y	N
Are needed numbers clearly marked?	Y	N
Emergency numbers? (police, fire, ambulance, etc.)	Y	N
Relatives? Neighbors?	Y	N
Is there a daily safety check system?	Y	N
Should there be an alert system like Lifeline?	Y	N
How will the client obtain mail?	Y	N

Family/Friends/Pets

Are the neighbors supportive?	Y	N
Does the client have family, friends, church/synagogue members To help and visit?	Y	N
Is the client able to take proper care of any pets?	Y	N
Are pets well-behaved?	Y	N

Description of living situation and areas of concern

Who does the shopping? How? _____

Who does the housework/yard work? _____

Who does the banking/other errands? _____

IV. Support System:

Name	Relationship	Phone #	Address	Ability/Willingness to Help Client

V. Spiritual/Social Factors:

Church Affiliation/Religion _____

What is important in your life right now? _____

What was important to you in the past? _____

How do you feel about getting older? _____

When you get discouraged or feel hopeless, what keeps you going? _____

Where have you found strength in the past? _____

If you have a personal means of meeting your inner spiritual needs (i.e. prayer, reading, etc.), please explain how you do this. _____

Please explain if you expect your life to be better or worse in the future? _____

What is your view on illness? _____

What is your view on dying? _____

How much of an impact has religion/faith had on your life?

Very much Some Little None

How much control do you believe you have over what happens to you in your life?

Very much Some Little None

How do you feel about accepting help? I accept help,

Very well Somewhat Not at all

What is your ethnic heritage? _____

How important is your ethnic origin on your life?

Very important Somewhat important Not important at all

Describe how you have met most of your friends (at work, church, neighbors, etc.) _____

Explain how you feel connected or separate from others _____

Other Social Activities (any recent changes) _____

Financial Factors:

a. Source of Income _____ Client Amount Monthly _____ Spouse Amount Monthly _____

b. Assets _____

c. Who handles finances? *Self* *Spouse* *Other*

d. Financial concerns? _____

e. Insurance: *Medicaid/Medicare* *Supplemental* _____ *Life* _____

Does Client Have: *Guardian* *POA* *Legal Concerns? If so, list:* _____

Client/Family Perception of Problems: (also see Family Questionnaire) _____

Summary of Assessment & Recommendations: _____

Environmental

Recommendations: _____

Financial

Recommendations: _____

Legal

Recommendations: _____

Medical

Recommendations: _____

Psychological

Recommendations: _____

Social

Recommendations: _____

RECOMMENDED PLAN OF CARE

Problem	Goal	Plan

ROLE OF THE PROFESSIONAL GERIATRIC CARE MANAGER IN ABOVE PLAN:

YOUR COMPANY NAME can assist in implementing the above plan We can make regular visits with... to ensure maximum benefits of socialization and activity, accompany... to those activities to ensure participation, and provide the family with availability 24 hours a day, seven days a week. We can offer support and encouragement for the family caregivers and advice during the transition phases of ...

Number of Visits to Client per Month: _____	Cost: <u>\$000.00/month</u>
Attend Care Conferences: <u>(if necessary)</u>	<u>N/C</u>
Make referrals to appropriate services as needed: <input type="checkbox"/>	<u>N/C</u>
Amount and type of Communication with Family: <input type="checkbox"/>	<u>N/C</u>
Medical Billing Assistance:	<u>N/A</u>
Assist with relocation if/when necessary: <u>(if necessary)</u>	(\$000.00) – 1x fee
Assist with MD/specialist appointments:	<u>\$000.00/month</u>
24-hr-day/7-day availability for emergency calls: <u>(if necessary)</u> includes unlimited telephone calls, one emergency visit per month; further emergency face- to-face visits would incur a fee of \$000/hour with prior authorization of payor.	<u>\$000.00/month</u>

Cost of Monthly monitoring of above plan, and beginning date: _____

Care Manager Signature _____ **Date** _____
(Signature covers all pages)

Supervisor Signature (if applicable) **Date** _____

We accept the Plan of Care as stated above and the stated costs

Client's Signature _____ **Date** _____
(or authorized family member/guardian/POA)