SENIOR VISIONARY SERVICES

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Date_____

Contact / Client Information

Client Name: _____Address_____ phone_____

Age: ___ DOB_____ Height_____ Weight____ Referred by: _____phone_____

Primary Doctor _____Address_____

Phone_____FAX:_____

Contact Name/Relationship: _____
Address:_____
Home phone:_____ Cell : _____Work: _____

Email of primary contact:_____

Name of POA/relationship/phone _____

Other family member in decision making & phone_____

Present living arrangement:_____

Prior living arrangement:_____

Current medical history/hospitalizations:_____

Check if appropriate: CHF COPD

Current communicable diseases and/or infections _____

Past medical history:_____

_____

History of drug or alcohol use_____

Medications / Allergies:

_____

_____

Is client diabetic? Insulin dependent? Pills? Shots # of times/day _____or Sliding scale_____

Can client manage own treatment / medication / equipment? If not, type of supervision:

Vision status: _____ Cataracts? Macular degeneration? Glaucoma? Glasses?

Can client read prescription labels?_____

Hearing status:_____ Aides?_____

Dental status: _____ Dentures? _____

Ambulatory status: _____Can patient bear weight? ____

Assistive devices?_____Cane_____Walker_____wheelchair _____Motorized scooter_____

Motor impairment / paralysis:_____

Based on physical / mental / vision condition?_____escorting needed?_____

Transfer status: Independent _____ One person assist_____ Two person assist _____ other_____

Bed status: Out of bed all day / in bed part of the time / in bed most of the time / in bed all of the time

Bathing assist: Showers_____upper body_____ lower body:_____ safety assist:_____

Dressing assist: upper body_____ lower body:_____safety assist:_____

Waking hours:_____ sleeping hours:_____Does client wander? _____

Toileting assist: _____ daytime _____ night time: _____

Bowel / Urinary incontinence?_____

Does client have any skin break down?_____skin tears?_____

Diet modifications / observation of food intake? _____

Assist with eating/drinking: _____swallowing difficulties? _____

Does client have any speech problems? _____Mild_____Moderate_____Aphasic_____

Dementia diagnosed: _____mild cognitive impairment: _____

Anxiety: _____other mental health issues: _____

Confused / disoriented: _____

Does client have pain?_____Some_____Moderate_____Severe_____

Where is the pain?_____

Does Client have any treatments?_____ _____

Able to follow instructions: _____

Depressed: _____Withdrawn_____

Able/willing to express needs: _____

Needs help in participating in activity programs: _____

Does client use Oxygen? _____Nebulizer treatments? _____How many times a day?____

Does client have a concentrator? _____ Is client able to fill and clean concentrator? _____

Has Client been in the Military? _____Is client applying for Military benefits? _____

Anticipated date of moving:_____

Location preference: _____

Room preference: Shared _____ Private_____One bedroom_____Two Bedroom_____

Financial concerns / budget: _____

_____

Notes/ Senior's interests, background:

_____

_____

_____

_____

CONSULTANT: _____

Note: This assessment does not take the place of a facility assessment according to RCFE guidelines. Senior's condition may have changed and senior has been assessed to the best of the ability of the consultant or family member.

I agree to share this information to responsible parties of RCFE communities which I will be advised prior to visiting.

_____ _____

Signature of Family Member: Date