First Nations Health Authority
Health through wellness

FNHA Home Care Program

# Care Assessment

| Type of Assessment ☐ Admission ☐ Re-Assessment | Case Manager | Assessment Date (YYYY/MM/DD) |
|---|---|---|

**CLIENT INFORMATION:**

| Surname | Given Name | Initial(s) | Home Phone No. | Home Care No. |
|---|---|---|---|---|
| First Nation Community | | | Work Phone No. | Status No. |
| Mailing Address (Street / Box No.) | City/Town, Province | | Postal Code | |
| Community Service Provided In ☐ Community Name ☐ Other | | | | MSP No. |
| Location Assessment Completed | ADVANCED CARE DIRECTIVE - DISCUSSED: ☐ YES or NO ☐ IN PLACE: ☐ YES or NO ☐ | | | Name of POA |

| If applicant does not have phone, can message be with nearest neighbor/relative? | ☐ Yes ■ No | Name | Message Phone No. |
|---|---|---|---|

| DATE OF BIRTH: | AGE: | GENDER: | LANGUAGES SPOKEN: |
|---|---|---|---|
| | | ☐ Male ■ Female | ☐ Indigenous: _____ ☐ English |

**MARITAL STATUS:**

☐ Child ☐ Married ☐ Divorced ☐ Separated ☐ Common Law ☐ Single ☐ Widow/Widower

**REFERRAL SOURCE:**

☐ Client ☐ Family ☐ Community Member ☐ Physician ☐ Nurse ☐ Hospital ☐ Social Services/CFS
☐ Rehab/OT/PT/RT ☐ Psychiatric Therapist/Nurse/Mental Health Worker ☐ Other: _____

| Physician | Address (Street / Box No.) City/Town, Province | Office Phone No. |
|---|---|---|
| Pharmacy | Address (Street / Box No.) City/Town, Province | Phone No. |

**NEXT OF KIN OR IN CASE OF EMERGENCY, NOTIFY;**

| Name | Relationship to Applicant | Home Phone No. |
|---|---|---|
| Address (Street / Box No.) City/Town, Province | First Nation Community | Work/Message Phone No. |
| Name | Relation to Applicant | Home Phone No. |
| Address (Street / Box No.) City/Town, Province | First Nation Community | Work/Message Phone No. |

**FAMILY INFORMATION / FUNCTIONAL ASSESSMENT**

**WHO LIVES IN THE SAME HOUSEHOLD WITH THE APPLICANT? (If none, write "NONE" in space.)**

| NAME | AGE | RELATIONSHIP | REMARKS: (Indicate if supportive of applicant and how.) |
|---|---|---|---|
| | | | |
| | | | |

**LIST RELEVANT FAMILY MEMBERS & FRIENDS (IF NONE, WRITE "NONE" IN SPACE.)**

| PLEASE CHECK (□) NEXT OF KIN OR LOCAL PERSON RESPONSIBLE. | | REMARKS: (Indicate distance, frequency of contact, supportiveness of applicant and how.) |
|---|---|---|
| Name | Phone No. | only contact in case of emergency |
| Address (Street / Box No.) City/Town, Province | First Nation Community | |
| Name | Phone No. | |
| Address (Street / Box No.) City/Town, Province | First Nation Community | |
| Name | Phone No. | |
| Address (Street / Box No.) City/Town, Province | First Nation Community | |

**ANY ADDITIONAL INFORMATION/ASSESSMENT RE: FAMILY FUNCTIONING PERTINENT TO ASSESSMENT FOR DELIVERY OF HOME CARE:**

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| HOUSEHOLD INFORMATION / FUNCTIONAL ASSESSMENT | | |
|---|---|---|
| **APPLICANT LIVES IN:** ☐ Own House ☐ Family Care ☐ Other (specify): _____ | | |
| **REMARKS:** | | |
| **INDICATE FACILITIES AVAILABLE AND ADEQUACY** | **AVAILABLE (Type)** | **ADEQUACY (yes / no; if no explain)** |
| **HEATING** | ☐ Wood ☐ Electricity ☐ Other: _____ | |
| **COOKING** | ☐ Wood ☐ Electricity ☐ Other: _____ | |
| **REFRIGERATION** | | |
| **LAUNDRY** | ☐ By Hand ☐ Has own appliance<br>☐ Laundromat ☐ Other: _____ | |
| **DRYING** | | |
| **WATER** | ☐ Hauls own water ☐ Running potable water<br>☐ Family hauls water ☐ Water delivered | |
| **TOILET** | ☐ Flush toilet ☐ Outhouse<br>☐ Indoor pail ☐ Other: _____ | |
| **BATHING** | ☐ Bathtub ■ Shower ☐ Other: _____ | |
| **STAIRS** | ■ Yes ☐ No | |
| **TELEPHONE** | ■ Yes ☐ No ☐ Internet access | |

| **HOUSEHOLD TASKS/MANAGEMENT** | **FORMERLY DONE BY APPLICANT** | **STILL DONE** | **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. |
|---|---|---|---|
| **LIGHT CLEANING** | ■ Yes ☐ No | ■ Yes ☐ No | |
| **HEAVY CLEANING** | ■ Yes ☐ No | ■ Yes ☐ No | |
| **PERSONAL LAUNDRY** | ■ Yes ☐ No | ■ Yes ☐ No | |
| **HOUSEHOLD LAUNDRY** | ■ Yes ☐ No | ■ Yes ☐ No | |
| **SHOPPING** | ■ Yes ☐ No | ■ Yes ☐ No | |
| **FULL MEAL PREPARATION** | ■ Yes ☐ No | ■ Yes ☐ No | |
| **LIGHT MEAL PREPARATION** | ■ Yes ☐ No | ■ Yes ☐ No | |
| **USE PHONE** | ■ Yes ☐ No | ■ Yes ☐ No | |
| **MANAGEMENT OF OWN AFFAIRS** | ■ Yes ☐ No | ■ Yes ☐ No | |

| HEALTH INFORMATION / HEALTH FUNCTIONAL ASSESSMENT | | | |
|---|---|---|---|
| **PHYSICAL HEALTH:** Does applicant have any health problems that limit their normal activity? | | | |
| ☐ Diabetes | ☐ Arthritis or Rheumatism | ☐ Emphysema or Bronchitis | ☐ Heart or Circulatory Problems |
| ☐ Pacemaker | ☐ Cancer | ☐ Muscular/Neurological Disorders (i.e. Effects of Stroke, Epilepsy) | |
| ☐ Operations | ☐ Accidents/Injuries | ☐ Psycho-Social | ☐ Other: _____ |
| **WHAT PROBLEMS DOES THIS CREATE FOR THE CLIENT?** | | | |
| | | | |
| **MAJOR CLINICAL FINDINGS:** | | | |
| Diagnosis / Extent of Disability: | | Diagnosis Known:<br>To Family ☐ Yes ☐ No To Applicant ■ Yes ☐ No | |
| **CLINICAL HISTORY: (i.e. Hospitalization / Surgery)** | | | |
| | | | |
| **ALLERGIES: (If any, describe; include food, medicine and environmental factors)** | | | |
| SULPHAS, BEES, SEASONAL ALLERGIES | | | |

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| MEDICATION | DOSAGE | FREQUENCY | ROUTE | PRESCRIBED BY | DATE (YYYY/MM/DD) |
|---|---|---|---|---|---|
| **See Form 007 – Medication Profile** | | | | | |

**USE OF TRADITIONAL MEDICINES / HERBS:**

☐ Yes ☐ No Specify:

**ABILITY TO ADMINISTER MEDICATION:**

☐ Independent
☐ Requires Assistance
☐ Blister pack

Specify:

Compliance:

**ANY ADDITIONAL INFORMATION/ASSESSMENT RE: PHYSICAL HEALTH FUNCTIONING PERTINENT TO THE ASSESSMENT FOR/DELIVERY OF HOME CARE:**

ct smokes 2 packs cigs / month

**PERSONAL CARE INFORMATION / FUNCTIONAL ASSESSMENT**

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

**SIGHT:**

Wears Glasses ☒ Yes ☐ No

When and Where glasses obtained? When:_____ (DD MM YYYY) Where: _____

Date last seen by Optometrist? _____ (DD MM YYYY)

☐ Adequate for all activities ☐ Inadequate for some activities (specify) ☐ Inadequate for personal safety (specify)

REMARKS:

**HEARING:**

Wears Hearing Aid: ☐ Right Ear ☐ Left Ear ☐ None

Type of batteries used? _____ Where batteries normally obtained? _____

Date hearing aid obtained? _____ (DD MM YYYY) Where hearing aid was obtained? _____

Date of last hearing test? _____ (DD MM YYYY) Place of last hearing test completed? _____

☐ Adequate for all activities ☐ Inadequate for some activities (specify) ☐ Inadequate for personal safety (specify)

REMARKS:

**COMMUNICATION:**

☐ Gestures Only ☐ Written Only
☐ Adequate for all activities ☐ Inadequate for some activities (specify) ☐ Inadequate for personal safety (specify)

REMARKS:

**NUTRITION:**

Is applicant eating adequately? ☐ Yes ☐ No
Is applicant on special diet? ☐ Yes ☒ No Who prescribed the special diet? _____
Has applicant received education on diet? ☐ Yes ☐ No Education received by? _____
☐ Own teeth ☐ Dentures ☐ Upper ☐ Lower ☐ Partial Date last fitted _____
☐ Independent ☐ Requires assistance or encouragement ☐ Has to be fed

REMARKS:

**AMBULATION:**

☐ Independent with or without mechanical aid ☐ Outdoors with assistance ☐ Stairs with assistance ☐ Stairs independent
☐ Cannot manage stairs ☐ Wheelchair independent ☐ Wheelchair with assistance

REMARKS:

**TRANSFERRING:**

☐ Independent ☐ Bed to chair with assistance ☐ Bedfast, can turn self in bed ☐ Bedfast, must be turned in bed

REMARKS:

**BATHING:**

☐ Independent ☐ Can sponge bath self ☐ Can bath only with assistance or encouragement ☐ Has to be bathed

REMARKS:

**CARE OF HAIR:**

☐ Independent ☐ Requires assistance or encouragement ☐ Cannot care for own hair

REMARKS:

**FOOT CARE:**

☐ Independent ☐ Requires assistance ☐ Cannot care for own feet

REMARKS:

**DRESSING:**

☐ Independent ☐ Requires assistance or encouragement ☐ Has to be dressed/undressed

REMARKS:

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**TOILETING:**

CONTINENCE ☐ Completely continent ☐ Incontinent urine ☐ occasionally ☐ Night only ☐ Always
☐ Incontinent feces ☐ occasionally ☐ Always

MANAGEMENT ☐ Independent
☐ Dependent (elaborate) ☐ Catheter ☐ Ostomy ☐ Condom Drainage ☐ Bathroom Routine ☐ Other Aids

REMARKS:

**SKIN AND CIRCULATION:**

Does applicant have any skin condition problems? ☐ Yes ☐ No Requires wound care? ☐ Yes ☒ No (see assessment form, if yes)

Any circulation condition problems? ☒ Yes ☐ No

Does applicant have any problems with their hands and/or feet? ☐ Yes ☒ No (Check Re: foot care)

REMARKS:

**SLEEPING PATTERN:**

Is applicant sleeping/resting adequately? ☐ Yes ☒ No Currently using medication for sleep? (i.e. over-counter) ☐ Yes ☐ No

No. of hours sleeping at night? _____ No. of hours/min resting / napping during day? _____

REMARKS:

**CARE FOR PROSTHESIS:**

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:**

**VITAL SIGNS:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **DATE (YYYY/MM/DD)** | 3 | **WT.** | | **BP** | | **PULSE** | | **TEMP.** | | **RESP.** | |
| **DATE (YYYY/MM/DD)** | | **WT.** | | **BP** | | **PULSE** | | **TEMP.** | | **RESP.** | |

**OTHER PROFESSIONALS:**

Is applicant currently seeing any of the following:
☐ Community Health Rep. ☐ Community Health Nurse ☐ Mental Health Worker ☐ Social Worker ☐ Other: _____

REMARKS:

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**ADMITTED:**

☐ Yes Date: _____ (YYYY MM DD) ☐ No Reason:

**APPEALED:**

☐ Yes Date: _____ (YYYY MM DD) ☐ No ☐ Admit ☐ Not for Admission at this time

**TYPE OF ADMISSION:**

☐ Regular ☐ Short Term ☐ Hospital Discharge Date: _____
☐ Other (explain)_____

**TYPE OF SERVICE:**

☐ Nursing ☐ Nursing Personal Care ☐ Supportive ☐ Continuous/Chronic ☐ Palliative

**FREQUENCY OF SERVICE:**

☐ Daily - ____Hrs/Day ☐ Weekly - ____Hrs/Wk ☐ Respite (Pre-arranged Times) ☐ Other (explain)_____

**FAMILY SUPPORT (*Circle One*): YES NO**

Date of Admission: _____ (YYYY MM DD)

Client ID #: _____ *(given when admitted into program)*

Assessor: _____ LPN/RN Date: _____ (YYYY/MM/DD)

Signature: _____