Manitoba Home Care Program
CARE ASSESSMENT FORM

Manitoba Health

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	☐	☐	☐	☐	
HOUSEHOLDLAUNDRY	☐	☐	☐	☐	
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 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.

18. SIGHT:

- ☐ Wears glasses ☐ Yes ☐ No
- ☐ Adequate for all activities
- ☐ Inadequate for some activities (specify)
- ☐ Inadequate for personal safety (specify)

REMARKS:

19. HEARING

- ☐ Wears hearing aid ☐ Yes ☐ No
- ☐ Adequate for all activities
- ☐ Inadequate for some activities (specify)
- ☐ Inadequate for personal safety (specify)

REMARKS:

20. COMMUNICATION:

- ☐ Gestures Only ☐ Written Only
- ☐ Adequate for all activities
- ☐ Inadequate for some activities (specify)
- ☐ Unable to communicate

REMARKS:

21. AMBULATION:

- ☐ Independent with or without mech. Aid
- ☐ Outdoors with assistance
- ☐ Indoors ambulation with assistance
- ☐ Stairs with assistance
- ☐ Stairs independent
- ☐ Cannot manage stairs
- ☐ Wheelchair independent
- ☐ Wheelchair with assistance

REMARKS:

22. TOILETING:

CONTINENCE

- ☐ Completely continent
- ☐ Incontinent urine, occasionally
- ☐ Incontinent urine, night only
- ☐ Incontinent urine, always
- ☐ Incontinent feces, occasionally
- ☐ Incontinent feces, always

MANAGEMENT

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

REMARKS:

23. TRANSFERRING:

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

REMARKS:

24. EATING:

Dentures: [ ] Upper [ ] Lower

- [ ] Independent
- [ ] Requires assistance or encouragement
- [ ] Has to be fed

REMARKS:

25. DRESSING:

- [ ] Independent
- [ ] Requires assistance or encouragement
- [ ] Has to be dressed/undressed

REMARKS:

26. BATHING:

- [ ] Independent
- [ ] Can sponge bath self
- [ ] Can bath only with assistance or encouragement
- [ ] Has to be bathed

REMARKS:

27. CARE OF HAIR:

- [ ] Independent
- [ ] Requires assistance or encouragement
- [ ] Cannot care for own hair

REMARKS:

28. FOOT CARE:

- [ ] Independent
- [ ] Requires Assistance
- [ ] Cannot care for own feet

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:

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.

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.

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?

33. Neighbours, friends in contact with applicant:

Name Phone #
Address

Name Phone #
Address

Name Phone #
Address

Name Phone #
Address

REMARKS: (Indicate frequency of contact and supportiveness to applicant and in what way.)

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

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?

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.

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

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

38. MENTAL STATUS:

- ☐ Completely oriented
- ☐ Forgetful/confused occ.
- ☐ Disoriented

REMARKS:

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:

40. MOTIVATION:

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

REMARKS:

41. JUDGEMENT IN PRESENT SITUATION:

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

REMARKS:

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.

HOUSEHOLD MAINTENANCE NEEDS

HEALTH NEEDS

PERSONAL CARE NEEDS

PSYCHO/SOCIAL NEEDS

SUPPLIES/EQUIPMENT NEEDS