

Initial Comprehensive Geriatric Assessment Form

Kernow Clinical Commissioning Group

Patient Contact	
<input type="checkbox"/>	Home
<input type="checkbox"/>	Care Home
<input type="checkbox"/>	GP
<input type="checkbox"/>	OPD
<input type="checkbox"/>	ED
<input type="checkbox"/>	Frailty
<input type="checkbox"/>	

Clinical Frailty Score (Rockwood Scale):	
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Patient's Details		Patient's Address	
Title		Add 1	
Name		Add 2	
Date of Birth		Add 3	
NHS Number		Town	
GP Practice		Postcode	

Cognition	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Mild Cognitive Impairment <input type="checkbox"/> Dementia <input type="checkbox"/> Delerium <input type="checkbox"/> Abbreviated Mental test (AMT) Score: <input type="text"/> Mental Capacity Assessment required Main lifelong occupation:			
Emotional	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Mood <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Fatigue <input type="checkbox"/> Hallucination <input type="checkbox"/> Delusion <input type="checkbox"/> Other			
Motivation	<input type="checkbox"/> High <input type="checkbox"/> Usual <input type="checkbox"/> Low			
Health Attitude	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Couldn't say			
Communication	Speech: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired Hearing: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired Vision: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired Understanding: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired			
Strength	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Weak Upper: <input type="checkbox"/> Proximal <input type="checkbox"/> Distal Lower: <input type="checkbox"/> Proximal <input type="checkbox"/> Distal			
Exercise	<input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Not			
Balance	Balance	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired		<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired
	Falls	<input type="checkbox"/> Falls Number: <input type="text"/>		<input type="checkbox"/> Falls Number: <input type="text"/>
Mobility	Walk inside	<input type="checkbox"/> Independent <input type="checkbox"/> Slow <input type="checkbox"/> Assisted <input type="checkbox"/> Can't		<input type="checkbox"/> Independent <input type="checkbox"/> Slow <input type="checkbox"/> Assisted <input type="checkbox"/> Can't
	Walk outside	<input type="checkbox"/> Independent <input type="checkbox"/> Slow <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Slow <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Transfers	<input type="checkbox"/> Independent <input type="checkbox"/> Standby <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Standby <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Bed (in/out)	<input type="checkbox"/> Independent <input type="checkbox"/> Pull <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Pull <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Aid use	<input type="checkbox"/> None <input type="checkbox"/> Stick <input type="checkbox"/> Frame <input type="checkbox"/> Chair		<input type="checkbox"/> None <input type="checkbox"/> Stick <input type="checkbox"/> Frame <input type="checkbox"/> Chair
Nutrition	Weight	<input type="checkbox"/> Normal <input type="checkbox"/> Under <input type="checkbox"/> Over <input type="checkbox"/> Obese		<input type="checkbox"/> Normal <input type="checkbox"/> Under <input type="checkbox"/> Over <input type="checkbox"/> Obese
	Appetite	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Fair <input type="checkbox"/> Poor
	Swallow	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired Fluids <input type="checkbox"/> Impaired Solids		<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired Fluids <input type="checkbox"/> Impaired Solids
Elimination	Bowel	<input type="checkbox"/> Continent <input type="checkbox"/> Constipated <input type="checkbox"/> Incontinent		<input type="checkbox"/> Continent <input type="checkbox"/> Constipated <input type="checkbox"/> Incontinent
	Bladder	<input type="checkbox"/> Continent <input type="checkbox"/> Catheter <input type="checkbox"/> Incontinent		<input type="checkbox"/> Continent <input type="checkbox"/> Catheter <input type="checkbox"/> Incontinent
ADLS	Feeding	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Bathing	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Dressing	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Toileting	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
IADLS	Cooking	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Cleaning	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Shopping	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Medications	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Driving	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
	Banking	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent		<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
Sleep	<input type="checkbox"/> Disrupted <input type="checkbox"/> Daytime drowsiness Socially Engaged <input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Not			
Social	Marital Status	Lives	Home	Supports
	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single	<input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Other	<input type="checkbox"/> House... Number of levels: <input type="text"/> <input type="checkbox"/> Steps... Number of steps: <input type="text"/> <input type="checkbox"/> Apartment <input type="checkbox"/> Supported Living <input type="checkbox"/> Care Home <input type="checkbox"/> Other	<input type="checkbox"/> Informal <input type="checkbox"/> Other <input type="checkbox"/> Requires more support <input type="checkbox"/> None

Advance directive in place:	<input type="checkbox"/> Yes <input type="checkbox"/> No
CPR decision:	<input type="checkbox"/> Allow a natural death <input type="checkbox"/> Resuscitate

Caregiver Relationship	Caregiver Stress
<input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Offspring <input type="checkbox"/> Other	<input type="checkbox"/> None <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High
Caregiver Occupation:	

Assessor:
 (Name, Grade & Signature)
 Date:

PLEASE TURN OVER

Problem List	Action Required	Action by:
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Long Term Conditions:

Notes:

Notes:

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- ☐ For MDT discussion, consider long CGA ☐ Long CGA **not** required, copy of Clinical Frailty score to GP

Outpatient Appointments

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Assessor: _____
(Name, Grade & Signature)

Date: _____