Manitoba Home Care Program
CARE ASSESSMENT FORM

Manitoba

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/Extent of Disability:

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 mechanical 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:	REMARKS:
_____ Independent _____ Bed to chair with assistance _____ Bedfast, can turn self in bed _____ Bedfast, must be turned in bed	
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	REMARKS:

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

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