Frimley Park Hospital NHS
NHS Foundation Trust

Comprehensive Geriatric Assessment Proforma

PATIENT DETAILS		CLERKING DOCTOR DETAILS	
Forename:		Name:	
Surname:		Grade:	
DOB and Age:	Male/Female:	Bleep:	Consultant:
Hospital Number:	*(Affix patient label here)*	Date:	Time:

HISTORY OF PRESENTING COMPLAINT

Source of information:
Patient ☐
Family/NOK ☐
Carer ☐
Paramedic Notes ☐
A&E Notes ☐
Other:_____

Cardiovascular: Chest Pain ☐ SOB ☐ Orthopnoea ☐ PND ☐ Oedema ☐ Palpitations ☐ Claudication ☐
Respiratory: Cough ☐ SOB ☐ Sputum ☐ Haemoptysis ☐ Wheeze ☐
Gastrointestinal Tract: Abdo pain ☐ Nausea ☐ Vomiting ☐ Diarrhoea ☐ Constipation ☐ PR blood ☐ Jaundice ☐
Genitourinary: Frequency ☐ Dysuria ☐ Nocturia ☐ Haematuria ☐ Prostatism ☐ Incontinence ☐
Nervous System: Headaches ☐ Fits / Faints / Funny turns ☐ Dizziness ☐ Weakness ☐ Visual Symptoms ☐ Hearing Sx ☐
Red Flag signs: Weight loss ☐ Appetite loss ☐ Tiredness/lethargy ☐ Back pain ☐ Change in bowel habits ☐

FALLS HISTORY

What do you think caused the fall? Slip or Trip?

Loss of consciousness Yes ☐ No ☐
Witnessed Yes ☐ No ☐

Injuries:

Activity at the time of fall:

Ability to get up from the floor unassisted: Yes ☐ No ☐

Place of fall: Time:

Recent changes to medications: Yes ☐ No ☐

Prodromal symptoms:
- Light-headed ☐
- Dizziness ☐
- Palpitations ☐
- Chest pain ☐
- Unilateral limb weakness ☐
- Other symptoms:

Post Event:
- Post-event weakness ☐
- Disorientation ☐
- Post-ictal ☐
- Urinary Incontinence ☐
- Tongue biting ☐

Footwear worn at time of fall:

Previous falls (describe):

Risk Factors

Past Medical History
- Epilepsy ☐
- Ischaemic heart disease ☐
- Heart failure ☐
- Stroke ☐
- Movement disorders – PD MSA PSP ☐
- Osteoarthritis ☐
- Osteoporosis (see below) ☐

Altered mental state
- Confusion ☐
- Sedation ☐
- Restlessness ☐
- Disorientation ☐

Balance Problems ☐
Gait Problems ☐
Chronic Pain ☐

Sensory problems
- Visual impairment ☐
- Hearing impairment ☐
- Speech impairment ☐
- Sensation ?Peripheral neuropathy ☐

Incontinence
- Faecal ☐
- Urinary ☐
- Urinary frequency ☐
- Urinary urgency ☐

Medications
- Polypharmacy (≥4 drugs) ☐
- Sedatives or antipsychotics ☐
- Anti-hypertensives ☐
- Opioids

- Previous falls in last year ☐
- Falls Team Involvement ☐
- Fear of falling? ☐
- Previous fractures ☐
- If yes, site of fractures:

Osteoporosis Risk Factors
- Smoking ☐
- Alcohol units/week _____ ☐
- Female ☐
- Early menopause ☐
- Family history ☐
- History of prolonged steroids ☐
- Vitamin D deficiency ☐

If yes, consider bone protection with bisphosphonates, calcium and vitamin D

PAST MEDICAL HISTORY

Active Medical Problems	Previous Surgery

MEDICATIONS

Name	Dose	Freq	Name	Dose	Freq

ALLERGIES AND REACTION

SOCIAL HISTORY

Alcohol: units/week

Smoking: Never / Passive / Ex- smoker / Current Smoker **Pack Year Hx:**

Occupation:

County: Surrey / Hampshire / Berkshire / Out of Area – Please state:

Accommodation Type:
- House ☐
- Flat – Floor ____ ☐
- Bungalow ☐
- Warden Controlled Flat ☐
- Residential Home ☐
- Nursing Home / EMI ☐
- Mobile Home ☐

Stairs/Steps: Yes ☐ No ☐
- No. of steps indoors ____
- No. of steps outdoors ____
- Stair lift ☐
- Stair rails ☐ X1 ☐ X2 ☐

Mobility:
- Independent ☐
- Stick/sticks ☐
- Frame/Wheeled trolley ☐
- Crutches ☐
- Wheelchair ☐
- Mobility Scooter ☐
- Driving ☐

Lives Alone: Yes ☐ No ☐

Pt main carer: Yes ☐ No ☐

Carers: Yes ☐ No ☐
- Spouse ☐
- Other Family ☐
- Friend / Neighbour ☐
- Formal Carers ☐
  - OD ☐ BD ☐ TDS ☐ QDS ☐
  - X1 ☐ X2 ☐

Privately funded carers?
Yes ☐ No ☐

Carer agency name and contact details:

Services:
- Care alarm ☐
- Key safe ☐
- Meals on Wheels ☐
- District Nurse ☐
- Community Matron ☐
- Day Centre ☐
- Bathing Services ☐

Home Equipment:
- Bathroom rails
- Mowbray toilet frame ☐
- Raised toilet seat ☐
- Free standing toilet frame ☐
- Reclining chair ☐
- Riser-recliner ☐
- Bed lever ☐
- Profile bed ☐
- Perching stool ☐
- Grab handles ☐
- ☐

FUNCTIONAL ASSESSMENT

Function	Preadmission	Present
Mobility		
Stairs		
Transfers		
Continence		
Washing /Dressing		
Medication	Dosset box Yes ☐ No ☐ MDS or Family Warfarin Yes ☐ No ☐	
Meal Preparation		
Shopping		
Cleaning		
Finances		

Functional status trend: **Baseline** ☐ **Improved** ☐ **Decline** ☐

Name: _____Sign: _____ Designation: _____ Contact: _____

COGNITION

Problems with memory in last 12 months?: Yes ☐ No ☐

Diagnosed Dementia: Yes ☐ No ☐

Previous AMTS: Yes ☐ No ☐
Score: Date:

Previous MMSE: Yes ☐ No ☐
Score: Date:

Abbreviated Mental Test

☐ Age	☐ WW1/2	
☐ Date of Birth	☐ Monarch	
☐ Year	☐ 20 → 1	
☐ Time	☐ Recall	
☐ Place	☐ Recognition	**Score:**

MOOD

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

*Answers in **bold** indicate depression. Score 1 point for each bolded answer.*

*Score **>5 points** is suggestive of depression.*

*Score **≥10 points** is almost always indicative of depression.*

*Score **>5 points** warrants follow-up with comprehensive assessment.*

EXAMINATION

Observations: T°C HR RR BP %

Weight (kg): **Height (cm):** **BMI:**

Lying/sitting BP:

Standing BP:

Post ambulatory BP:

Jaundice ☐ Anaemia ☐ Cyanosis ☐ Clubbing ☐ Lymphadenopathy ☐ A V P U

GCS: E V M /15

Pulse: _____ bpm Regular / Irregular

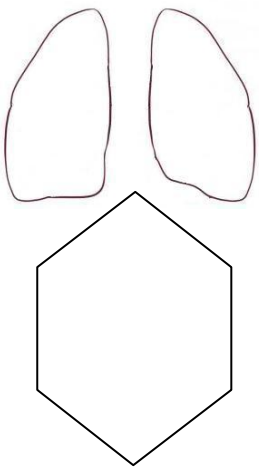
JVP raised: Yes / No

HS:

Carotid bruits: Yes / No

Oedema:

Peripheral Pulses:



PR:

Transfers:

Lying to SOEOB:

SOEOB to lying:

Sit (chair) to stand:

SOEOB to stand:

Gait:

Balance:

	RIGHT	**LEFT**	Cranial Nerves
	POWER:	POWER:	
U	TONE:	TONE:	
P	REFLEXES:	REFLEXES:	
P	Biceps	Biceps	
E	Supinator	Supinator	
R	Triceps	Triceps	
	COORDINATION:	COORDINATION:	
	SENSATION:	SENSATION:	
L	POWER:	POWER:	
O	TONE:	TONE:	
W	REFLEXES:	REFLEXES:	Cerebellar Signs
E	Knee	Knee	
R	Ankle	Ankle	
	Plantars	Plantars	
	COORDINATION:	COORDINATION:	
	SENSATION:	SENSATION:	

IMPRESSION / PROBLEMS LIST

MANAGEMENT PLAN

Bone Protection Yes ☐ No ☐
VTE Prophylaxis Yes ☐ No ☐

Name: _____Sign: _____ Designation: _____ Contact: _____

INVESTIGATIONS

ECG:

CT Head:

CXR:

Other imaging:

Urinalysis Results:

pH
Blood
Leucocytes
Nitrites
Ketones
Protein
Glucose

Catheter in situ: Yes ☐ No ☐

Microscopy/Cultures/Sensitivities:

Venous / Arterial Blood Gas:

Date & Time			
pH			
pO2			
pCO2			
Base Excess			
HCO3			
Lactate			
Glucose			
Hb			
K+			

BASELINE BLOODS

Date:											
WCC											
Neut											
Hb											
MCV											
Plts											
CRP											
Na											
K											
Ur											
Cr											
eGFR											
aCa											
Phos											
Mag											
Alb											
Bil											
ALP											
ALT											
GGT											
INR											
CK											
Glucose											

Cortisol		**Vit D**									
TSH		**Trop**									
FT3											
FT4											
B_{12}											
Folate											
Ferritin											

POST-TAKE WARD ROUND

Consultant: **Date:**

Time:

ECG:

CXR:

Imaging:

Urinanalysis:

Impression:

Obs:

METS Score:

Plan:

VTE Prophylaxis Yes ☐ No ☐

Advanced Care Planning

DNAR: Yes ☐ No ☐ Not discussed ☐

Active Advanced Directive: Yes ☐ No ☐

Power of Attorney: Yes ☐ No ☐ If yes, who_____

Name: _____Sign: _____ Designation: _____ Contact: _____

PHYSIOTHERAPY ASSESSMENT

Functional Assessment (Mobility/Transfers): **Date:** **Time:**

Elderly Mobility Scale (EMS) Score: /20

Balance Assessment:

TUSS (aim 60 seconds)

Standing, feet together & eyes **open** No. of secs Independent ☐ Supervision ☐ Unable ☐

Standing, feet together & eyes **closed** No. of secs Independent ☐ Supervision ☐ Unable ☐

(aim 10 seconds)

180° turn

Right: No. of steps No. of touches

Left: No. of steps No. of touches

Walking aid used Yes ☐ No ☐ Type_____

(>4 steps = increased falls risk)

Stair Assessment:

Main stairs ☐ Physiotherapy Department ☐

Safe ☐ Unsafe ☐

Plan/Recommendation:

Physiotherapist Name: _____ _____ Sign: _____

Designation: _____ Contact details: _____

INREACH

Date: **Time:**

Referral:	Rapid Response ☐	Virtual Ward/ Community Matron ☐	Social Services ☐ Reablement ☐	Rehabilitation / Step-up bed ☐

Inreach Name: _____ Sign: _____
Designation: _____ Contact details: _____

OCCUPATIONAL THERAPY

Date: **Time:**

Occupational Therapist Name: _____ Sign: _____
Designation: _____ Contact details: _____

APPENDIX

CURB-65

Confusion	1
Urea >7 mmol/l	1
Respiratory Rate >30	1
Systolic BP <90, Diastolic BP <60	1
Age >65	1

0-1: Treat as an outpatient
2-3: Consider a short stay in hospital or watch very closely as an outpatient
4-5: Requires hospitalization. Consider intensive care unit admission

HASBLED Risk

Hypertension	1
Abnormal renal and liver function	1 or 2
Stroke	1
Bleeding	1
Labile INRs	1
Elderly (>65)	1
Drugs or alcohol (1 point each)	1 or 2

0-2: Low or intermediate risk
≥3: High risk

CHA2DS2-VASc Risk

Congestive Heart Failure	1
Hypertension	1
Age >75	2
Diabetes Mellitus	1
Stroke or TIA	2
Vascular Disease	1
Age 65-75	1
Sex (female)	1

0: No antithrombotic therapy is recommended
1: Oral anticoagulation should be considered
≥2: Oral anticoagulation is recommended

Wells Prediction Score - DVT

Active cancer	1
Calf swelling ≥3 cm	1
Collateral superficial veins	1
Pitting oedema	1
Swelling of entire leg	1
Localised tenderness along deep venous system	1
Paralysis, paresis, recent cast immobilisation	1
Bedridden <3/major surgery	1
Previous DVT	1
Alternative diagnosis likely	-2

≥2: DVT is likely
<2: DVT is unlikely

Wells Prediction Score - PE

Previous DVT or PE	1.5
Recent surgery or immobilization	1.5
Cancer	1
Haemoptysis	1
Heart rate >100 beats/min	1.5
Clinical signs of DVT	3
Alternative diagnosis less likely	3

0-1: Low
2-6: Intermediate
≥7: High

EYES	VOICE	MOVEMENT
4 Open spontaneously	5 Oriented	6 Obeys commands
3 Open to speech	4 Confused	5 Localises pain
2 Open to pain	3 Inappropriate words	4 Flexion withdrawal
1 Never open	2 Inappropriate sounds	3 Decerebrate flexion
	1 Silent	2 Decerebrate extension
		1 No movement

GCS /15

USEFUL CONTACTS

Virgin Care - **Tel**: 01483 782644

Southern Health: - **Tel**: 0845 582 1252 **Email:** hp-tr.SPA-fleet@nhs.net

Bracknell: - **Tel**: 0844 406 0979 **Fax**: 01189 893110 E-**mail**: bks-tr.healthhub@nhs.net