SECTION A. Identification Information

1. NAME

_____

a. (First) b. (Middle Initial) c. (Last) d. (Jr./Sr.)

2. GENDER ☐
1 Male **2** Female

3. BIRTHDATE ☐☐ — ☐☐ — ☐☐☐☐
Day Month Year

4. MARITAL STATUS ☐
1 Never married
2 Married
3 Partner / Significant other
4 Widowed
5 Separated
6 Divorced

5. ETHNICITY / RACE [EXAMPLE—AUSTRALIA]

a. **Country of birth**

Specify: _____

b. **City of birth**

Specify: _____

c. **Indigenous status** ☐
Is the client of Aboriginal or Torres Strait Islander origin?
1 Yes, Aboriginal
2 Yes, Torres Strait Islander
3 Yes, both
4 No, neither

6. PRIMARY LANGUAGE [EXAMPLE—AUSTRALIA]

Main language spoken at home ☐
1 English
2 Other
Specify: _____

7. HOSPITAL
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

8. WARD [EXAMPLE—AUSTRALIA]
☐☐☐☐

9. TREATING DOCTOR
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

10. NATIONAL NUMERIC IDENTIFIER [EXAMPLE—AUSTRALIA]
☐☐☐☐ ☐☐☐☐☐ ☐

11. FACILITY / AGENCY PROVIDER NUMBER (STATE SPECIFIC) [EXAMPLE—AUSTRALIA]
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

12. CURRENT PAYMENT SOURCES FOR INPATIENT STAY [EXAMPLE—AUSTRALIA] ☐

Hospital insurance status
1 Private insurance
2 No private health insurance
3 Not stated / unknown

_____

NOTES:

SECTION B. Intake and Initial History

[Note: Complete Section B at Admission / First Assessment only]

1. DATE STAY BEGAN
☐☐ — ☐☐ — 2 0 ☐☐
Day Month Year

2. ADMITTED FROM ☐☐
1 Private residence—owned / purchasing
– Client owns / is purchasing
– Family member or related person owns / is purchasing
2 Private residence—private rental
3 Private residence—public rental or community housing; indigenous community / settlement
4 Independent living within a retirement village
5 Boarding house / rooming house / private hostel
6 Supported community accommodation
7 Short-term crisis, emergency, or transitional accommodation
8 Mental health residence—e.g., psychiatric group home
9 Group home for persons with physical disability
10 Setting for persons with intellectual disability
11 Residential aged care service—low-level care
12 Residential aged care service—high-level care
13 Acute care hospital
14 Hospice facility / palliative care unit
15 Rehabilitation hospital / unit
16 Psychiatric hospital or unit
17 Correctional facility
18 Public place / temporary shelter
19 Other

3. LIVING ARRANGEMENT PRIOR TO ADMISSION ☐
1 Alone
2 With spouse / partner only
3 With spouse / partner and other(s)
4 With child (not spouse / partner)
5 With parent(s) or guardian(s)
6 With sibling(s)
7 With other relative(s) (not spouse or children)
8 With non-relative(s)
9 In residential care / other institutional setting

4. PRECIPITATING EVENT PRIOR TO ADMISSION ☐

Time of the onset of the precipitating event / problem that directly preceded admission into this facility (time from date stay began—Item B1)

0 Within last 7 days
1 8–14 days ago
2 15–30 days ago
3 31–60 days ago
4 More than 60 days ago

5. TIME SINCE LAST HOSPITAL STAY ☐

Code for most recent instance in LAST 90 DAYS

0 No hospitalization within 90 days
1 31–90 days ago
2 15–30 days ago
3 8–14 days ago
4 In the last 7 days
5 Transferred from another hospital

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6. TIME SPENT IN EMERGENCY ROOM ☐

- **0** Not admitted via emergency room
- **1** 0–8 hours
- **2** 8–24 hours
- **3** 24–48 hours
- **4** More than 48 hours

NOTES:

SECTION C. Assessment Dates

1. ASSESSMENT REFERENCE DATES

a. **Admission assessment**

☐☐ — ☐☐ — ☐☐☐☐
Day Month Year

b. **Review assessment**

☐☐ — ☐☐ — ☐☐☐☐
Day Month Year

c. **Discharge assessment**

☐☐ — ☐☐ — ☐☐☐☐
Day Month Year

NOTES:

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NOTE: If the initial assessment is conducted more than 3 days after admission, use the column "Admission" and assess the 24 hours immediately prior. Day 14 assessments should utilize the "Review" column.

Pre-morbid | Admission | Review | Discharge

SECTION D. Cognition

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING

Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do

- **0 Independent**—Decisions consistent, reasonable, safe
- **1 Modified independence**—Some difficulty in new situations only
- **2 Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
- **3 Moderately impaired**—Decisions consistently poor or unsafe, cues / supervision required at all times
- **4 Severely impaired**—Never / rarely makes decisions
- **5 No discernable consciousness, coma** [For pre-morbid assessment, continue with Sections D to G; for all other assessments skip to Section H]

2. MEMORY / RECALL ABILITY

Code for recall of what was learned or known

0 Yes, memory OK **1** Memory problem

a. **Short-term memory OK**—Seems / appears to recall after 5 minutes

b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues

c. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS

[Note: Accurate assessment requires conversations with staff, family, or others who have direct knowledge of the person's behaviour over this time]

- **0** Behaviour not present
- **1** Behaviour present, consistent with usual functioning
- **2** Behaviour present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked

b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought

c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—e.g., restlessness, lethargy, difficult to arouse, altered environmental perception

0 No **1** Yes

NOTES:

SECTION E. Communication and Vision

1. MAKING SELF UNDERSTOOD (Expression)

Expressing information content—both verbal and non-verbal

- **0 Understood**—Expresses ideas without difficulty
- **1 Usually understood**—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
- **2 Often understood**—Difficulty finding words or finishing thoughts AND prompting usually required
- **3 Sometimes understood**—Ability is limited to making concrete requests
- **4 Rarely or never understood**

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)

Understanding verbal information content (however able; with hearing appliance normally used)

- **0 Understands**—Clear comprehension
- **1 Usually understands**—Misses some part / intent of message BUT comprehends most conversation
- **2 Often understands**—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
- **3 Sometimes understands**—Responds adequately to simple, direct communication only
- **4 Rarely or never understands**

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Pre-morbid | Admission | Review | Discharge

3. HEARING

Ability to hear (with hearing appliance normally used)

- **0 Adequate**—No difficulty in normal conversation, social interaction, listening to TV
- **1 Minimal difficulty**—Difficulty in some environments (e.g., when person speaks softly or is more than 2 metres away)
- **2 Moderate difficulty**—Problem hearing normal conversation, requires quiet setting to hear well
- **3 Severe difficulty**—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- **4 No hearing**

4. VISION

Ability to see in adequate light (with glasses or with other visual appliance normally used)

- **0 Adequate**—Sees fine detail, including regular print in newspapers / books
- **1 Minimal difficulty**—Sees large print, but not regular print in newspapers / books
- **2 Moderate difficulty**—Limited vision; not able to see newspaper headlines, but can identify objects
- **3 Severe difficulty**—Object identification in question, but eyes appear to follow objects; sees only light, colours, or shapes
- **4 No vision**

NOTES:

SECTION F. Mood and Behaviour

1. SELF-REPORTED MOOD

Use 3-day period for pre-morbid and 24-hour period for other assessments

- **0** Not in the 3 days / last 24 hours
- **1** Not in the 3 days / last 24 hours, but often feel that way
- **2** Yes, felt that way in the 3 days / last 24 hours
- **8** Person could not (would not) respond

Ask: "In the last 3 days / 24 hours, how often have you felt . . ."

a. **Little interest or pleasure in the things you normally enjoy?**

b. **Anxious, restless, or uneasy?**

c. **Sad, depressed, or hopeless?**

2. BEHAVIOUR SYMPTOMS

In LAST 3 DAYS / 24 HOURS, presence of any one or more of the following: verbal abuse, physical abuse, resisting care, socially inappropriate or disruptive behaviour.

0 No **1** Yes

NOTES:

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SECTION G. Functional Status

1. ADL SELF-PERFORMANCE

Consider all episodes over LAST 3 DAYS for pre-morbid and LAST 24 HOURS for review and discharge assessment periods.

*If **all** episodes are performed at the same level, score ADL at that level.*

*If **any** episodes at level 6, and others less dependent, score ADL as a 5.*

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2–5.

0 Independent—No physical assistance, set-up, or supervision in any episode
1 Independent, set-up help only—Article or device provided or placed within reach, no physical assistance or supervision in any episode
2 Supervision—Oversight / cueing
3 Limited assistance—Guided manoeuvering of limbs, physical guidance without taking weight
4 Extensive assistance—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5 Maximal assistance—Weight-bearing support (including lifting limbs) by 2+ helpers—OR—Weight-bearing support for more than 50% of subtasks
6 Total dependence—Full performance by others during all episodes
8 Activity did not occur—During entire period

	Pre-morbid	Admission	Review	Discharge
a. **Bathing**—How takes a full-body bath or shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area—EXCLUDE WASHING OF BACK AND HAIR				
b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands—EXCLUDE BATHS AND SHOWERS				
c. **Walking**—How walks between locations on same floor indoors				
d. **Transfer toilet**—How moves on and off toilet or commode				
e. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes—EXCLUDE TRANSFER ON AND OFF TOILET				
f. **Bed mobility**—How moves to and from lying position, turns side to side, and positions body while in bed				
g. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)				

2. LOCOMOTION / WALKING

	Pre-morbid	Admission	Review	Discharge
a. **Primary mode of locomotion**				

0 Walking, no assistive device
1 Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair
2 Wheelchair, scooter
3 Bed-bound

	Pre-morbid	Admission	Review	Discharge
b. **Distance walked**—Furthest distance walked at one time without sitting down in the LAST 3 DAYS pre-morbid or 24 HOURS for review and discharge assessment periods (with support as needed)				

0 Did not walk
1 Less than 5 metres
2 5–49 metres
3 50–99 metres
4 100–999 metres
5 1 kilometre or more

	Pre-morbid	Admission	Review	Discharge
c. **Distance wheeled self**—Furthest distance wheeled self at one time in the LAST 3 DAYS pre-morbid or 24 HOURS for review and discharge assessment periods (includes independent use of motorized wheelchair)				

0 Wheeled by others
1 Used motorized wheelchair / scooter
2 Wheeled self less than 5 metres
3 Wheeled self 5–49 metres
4 Wheeled self 50–99 metres
5 Wheeled self 100+ metres
8 Did not use wheelchair

3. ACTIVITY LEVEL

In the 3 days prior to the onset of the illness precipitating admission, number of days went out of the house or building in which he / she resides (no matter how short the period)

0 No days out
1 Did not go out in last 3 days, but usually goes out over a 3-day period
2 1–2 days
3 3 days

4. CONFINED TO BED

Patient is confined to bed for medical reasons

0 No **1** Yes

5. IADL SELF PERFORMANCE AND CAPACITY

*For **pre-morbid** period, code PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS prior to onset of acute illness precipitating admission.*

*For **admission**, **review**, and **discharge** periods, code CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor. The column for admission should only be completed if the initial assessment is conducted more than 3 days after admission, enabling the ability to assess capacity.*

0 Independent—No help, set-up, or supervision
1 Set-up help only
2 Supervision—Oversight / cueing
3 Limited assistance—Help on some occasions
4 Extensive assistance—Help throughout task, but performs 50% or more of task on own
5 Maximal assistance—Help throughout task but performs less than 50% of task on own
6 Total dependence—Full performance by others during entire period
8 Activity did not occur—During entire period (DO NOT USE THIS CODE IN SCORING CAPACITY)

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	Pre-morbid	Admission	Review	Discharge
a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)	☐	☐	☐	☐
b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	☐	☐	☐	☐
c. **Managing finances**—How bills are paid, chequebook is balanced, household expenses are budgeted, credit card account is monitored	☐	☐	☐	☐
d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	☐	☐	☐	☐
e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	☐	☐	☐	☐
f. **Stairs**—How full flight of stairs is managed (12–14 stairs)	☐	☐	☐	☐
g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money) EXCLUDE TRANSPORTATION	☐	☐	☐	☐
h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house; into / out of vehicles)	☐	☐	☐	☐

NOTES:

SECTION H. Continence

1. BLADDER CONTINENCE ☐☐☐☐

- **0 Continent**—Complete control; DOES NOT USE any type of catheter or other urinary collection device
- **1 Control with any catheter or ostomy** over last 3 days / 24 hours
- **2 Infrequently incontinent**—Not incontinent over last 3 days / 24 hours, but does have incontinent episodes
- **3 Occasionally incontinent**—Less than daily *[Note: This code is only available for the pre-morbid period]*
- **4 Frequently incontinent**—Incontinent daily, but some control present
- **5 Incontinent**—No control present
- **8 Did not occur**—No urine output from bladder in last 3 days / 24 hours

2. URINARY COLLECTION DEVICE (Exclude pads, briefs) ☐☐☐☐

- **0** None
- **1** Condom catheter
- **2** Indwelling catheter
- **3** Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE ☐☐☐☐

- **0 Continent**—Complete control; DOES NOT USE any type of ostomy device
- **1 Control with ostomy**—Control with ostomy device over last 3 days / 24 hours
- **2 Infrequently incontinent**—Not incontinent over last 3 days / 24 hours, but does have incontinent episodes
- **3 Occasionally incontinent**—Less than daily *[Note: This code is only available for the pre-morbid period]*
- **4 Frequently incontinent**—Daily, but some control present
- **5 Incontinent**—No control present
- **8 Did not occur**—No bowel movement in the last 3 days / 24 hours

4. PADS, BRIEFS WORN ☐☐☐☐

0 No **1** Yes

NOTES:

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SECTION I. Disease Diagnoses

1. DISEASE DIAGNOSES

Diseases that have a relationship to current ADL status, cognitive status, mood or behaviour status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses.)

Disease code
- **1** Primary diagnosis / diagnoses for current stay
- **2** Diagnosis present, receiving active treatment
- **3** Diagnosis present, monitored but no active treatment

a. **Admission (working) diagnoses**

	Diagnosis	Disease Code
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

b. **Discharge (final) diagnoses**

	Diagnosis	Disease Code
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

NOTES:

SECTION J. Health Conditions

Pre-morbid | Admission | Review | Discharge

1. FALLS

a. Fell in last 90 days prior to admission
- **0** No fall in last 90 days
- **1** No fall in last 30 days, but fell 31–90 days ago
- **2** One fall in last 30 days
- **3** Two or more falls in last 30 days

b. Fell in last 72 hours prior to admission
- **0** No
- **1** Yes

c. Fell in hospital since admission
- **0** No
- **1** Yes

d. Fell in hospital since most recent review assessment
- **0** No
- **1** Yes

2. RECENT FALLS

[Skip if last assessed more than 30 days ago or if this is a first assessment]

Person fell since last assessment
- **0** No
- **1** Yes
- **[blank]** Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY

0 Not present **1** Present

Balance

a. **Difficult or unable to move self to standing position unassisted**

b. **Difficult or unable to turn self around and face the opposite direction when standing**

GI Status

c. **Nausea**

4. DYSPNOEA (Shortness of breath)

- **0** Absence of symptom
- **1** Absent at rest, but present when performed moderate activities
- **2** Absent at rest, but present when performed normal day-to-day activities
- **3**. Present at rest

5. FATIGUE

Inability to complete normal daily activities—e.g., ADLs, IADLs

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Pre-morbid | Admission | Review | Discharge

0 None
1 Minimal—Diminished energy but completes normal day-to-day activities

2 Moderate—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
3 Severe—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
4 Unable to commence any day-to-day activities—Due to diminished energy

6. PAIN SYMPTOMS

[Note: Always ask the person about frequency, intensity, and control. Observe person and ask others who are in contact with person.]

a. **Frequency with which person complains or shows evidence of pain** (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain) ☐☐☐☐
0 No pain
1 Present but not exhibited in last 3 days / 24 hours
2 Exhibited in last 3 days / 24 hours

b. **Intensity of highest level of pain present** ☐☐☐☐
0 No pain
1 Mild
2 Moderate
3 Severe
4 Times when pain is horrible or excruciating

c. **Consistency of pain** ☐☐☐☐
0 No pain
1 Single episode in last 3 days / 24 hours
2 Intermittent
3 Constant

7. SELF REPORTED HEALTH

Ask: "In general, how would you rate you health?"
0 Excellent
1 Good
2 Fair
3 Poor
8 Could/would not respond ☐☐■■

SECTION K. Oral and Nutritional Status

1. HEIGHT AND WEIGHT [EXAMPLE—AUSTRALIA]

Record (a.) height in cm and (b.) weight in kg. Base weight on most recent measure in LAST 30 DAYS

a. **HT** (cm) ☐☐☐ b. **WT** (kg) ☐☐☐

2. NUTRITIONAL ISSUES ■☐■■
0 No **1** Yes

Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS

3. MODE OF NUTRITIONAL INTAKE ☐☐☐☐
0 Normal—Swallows all types of food
1 Modified independent—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
2 Requires diet modification to swallow solid food—e.g., mechanical diet (pureed, minced, etc.) or only able to ingest specific foods
3 Requires diet modification to swallow liquids—e.g., thickened liquids
4 Can swallow only pureed solids—AND—**thickened liquids**
5 Combined oral and parenteral or tube feeding
6 Nasogastric tube feeding only
7 Abdominal feeding tube—e.g., PEG tube
8 Parenteral feeding only—Includes all types of parenteral feeding, such as total parenteral nutrition (TPN)
9 Activity did not occur—During entire period

NOTES:

SECTION L. Skin Condition

1. MOST SEVERE PRESSURE ULCER ■☐☐☐
0 No pressure ulcer
1 Any area of persistent skin redness
2 Partial loss of skin layers
3 Deep craters in the skin
4 Breaks in skin exposing muscle or bone
5 Not codeable—e.g., necrotic eschar predominant

2. PRIOR PRESSURE ULCER ☐■■■
Previous pressure ulcer, now healed
0 No **1** Yes

NOTES:

SECTION M. Medications

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over-the-counter) medications taken in the LAST 24 HOURS

[Note: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug, record:

a. **Name**

b. **Dose**—A positive number such as 0.5, 5, 150, 300
[Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]

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c. **Unit**—Code using the following list:

gtts	(drops)	**L**	(litres)	**mEq**	(milliequivalent)	**ml**	(millilitres)	**puffs**	(puffs)	**units**	(units)
gm	(grams)	**mcg**	(micrograms)	**mg**	(milligrams)	**oz**	(ounces)	**%**	(percent)	**oth**	(other)

d. **Route of administration**—Code using the following list:

PO	(by mouth)	**IV**	(intravenous)	**REC**	(rectal)	**IH**	(inhalation)	**ET**	(enteral tube)	**EYE**	(eye)
SL	(sublingual)	**Sub-Q**	(subcutaneous)	**TOP**	(topical)	**NAS**	(nasal)	**TD**	(transdermal)	**OTH**	(other)
IM	(intramuscular)										

e. **Frequency**—Code the number of times per day, week, or month the medication is administered using the following list:

Q1H	(every hour)	**Q8H**	(every 8 hours)	**TID**	(3 times daily)	**Weekly**		**6W**	(6 times weekly)
Q2H	(every 2 hours)	**Daily**		**QID**	(4 times daily)	**2W**	(2 times weekly)	**1M**	(monthly)
Q3H	(every 3 hours)	**BED**	(at bedtime)	**5D**	(5 times daily)	**3W**	(3 times weekly)	**2M**	(twice each month)
Q4H	(every 4 hours)	**BID**	(2 times daily;	**Q2D**	(every other day)	**4W**	(4 times weekly)	**OTH**	(other)
Q6H	(every 6 hours)		includes every 12 hrs)	**Q3D**	(every 3 days)	**5W**	(5 times weekly)		

f. **PRN**

0 No **1** Yes

g. **Computer-entered drug code**

Admission medications

	a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. ATC or NDC code
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

Discharge medications

	a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. ATC or NDC code
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

NOTES:

	Pre-morbid	Admission	Review	Discharge
2. ALLERGY TO ANY DRUG				
0 No known drug allergies **1** Yes	■	□	■	□

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SECTION N. Treatments and Procedures

1. SURGERY

a. **Surgical procedure conducted in hospital since admission?**

0 No **1** Yes

b. **Date of procedure**

Day — Month — Year

a. **Surgical procedure conducted in hospital since most recent review asssesment?**

0 No **1** Yes

b. **Date of procedure**

Day — Month — Year

2. SPECIAL TREATMENTS, THERAPIES, PROGRAMS

Treatments and programs required after discharge

0 No **1** Yes

	Pre-morbid	Admission	Review	Discharge
a. **Chemotherapy**				
b. **Dialysis**				
c. **IV medication**				
d. **Oxygen therapy**				
e. **Radiation**				
f. **Suctioning**				
g. **Tracheostomy care**				
h. **Transfusion**				
i. **Ventilator or respirator**				
j. **Wound care**				
k. **Nasogastric feeding**				
l. **PEG feeding**				
m. **Parenteral feeding**				

3. THERAPY / NURSING SERVICES

By qualified staff (e.g., therapist or therapy assistant under direction of therapist)

0 No **1** Yes

	Pre-morbid	Admission	Review	Discharge
a. **Physical therapy**				
b. **Occupational therapy**				
c. **Speech-language pathology and audiology services**				
d. **Respiratory therapy**				
e. **Functional rehabilitation / walking program by licensed nurse**				
f. **Psychological therapy (by any licensed mental health professional)**				

SECTION O. Responsibility and Directives

1. LEGAL GUARDIAN [EXAMPLE—AUSTRALIA]

0 No **1** Yes

2. ADVANCE DIRECTIVES [EXAMPLE—AUSTRALIA]

0 Not in place **1** In place

	Pre-morbid	Admission	Review	Discharge
a. **Advance directives for not resuscitating**				
b. **Advance directives for not intubating**				
c. **Advance directives for not hospitalizing**				
d. **Advance directives for no tube feeding**				
e. **Advance directives for medication restriction**				
f. **Advance directives for other treatment restrictions**				
g. **Advance directives for comfort measures only**				

SECTION P. Discharge Potential

1. PRIOR COMMUNITY SERVICES

Was the person receiving formal (other than family and friends) support services prior to admission?

0 No
1 Yes
2 Living in institutional setting

2. COMMUNITY SERVICES PRIOR TO ADMISSION [EXAMPLE—AUSTRALIA]

0 No **1** Yes

	Pre-morbid	Admission	Review	Discharge
a. **Housekeeping**				
b. **Delivered meals**				
c. **Home maintenance**				
d. **Home nursing**				
e. **Medication aid**				
f. **Personal care assistance**				
g. **Day care**				
h. **Respite**				
i. **Packaged care (EACH/CAP)**				
j. **Other** Specify: _____				

3. INFORMAL HELPER STATUS

0 No
1 Yes
2 Living in institutional setting

	Pre-morbid	Admission	Review	Discharge
a. **Has a support person who is positive towards discharge or maintaining residence in the community**				
b. **Family or close friends report being overwhelmed by the person's illness**				

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4. ACCESS TO USUAL RESIDENCE

a. **Has housing available in the community**

0 No
1 Yes

b. Person is required to climb two or more steps to access home or important rooms in the home (e.g., bathroom, bedroom)

0 No
1 Yes

SECTION Q. Discharge

Code Section Q at Discharge only

1. LAST DAY OF STAY

☐☐ — ☐☐ — 2 0 ☐☐
Day Month Year

2. DISCHARGED TO

1 Private residence—owned / purchasing
– Client owns / is purchasing
– Family member or related person owns / is purchasing
2 Private residence—private rental
3 Private residence—public rental or community housing; indigenous community / settlement
4 Independent living within a retirement village
5 Boarding house / rooming house / private hostel
6 Supported community accommodation
7 Short-term crisis, emergency, or transitional accommodation
8 Mental health residence—e.g., psychiatric group home
9 Group home for persons with physical disability
10 Setting for persons with intellectual disability
11 Residential aged care service—low-level care
12 Residential aged care service—high-level care
13 Acute care hospital
14 Hospice facility / palliative care unit
15 Rehabilitation hospital / unit
16 Psychiatric hospital or unit
17 Correctional facility
18 Public place / temporary shelter
19 Other
20 Deceased

NOTES:

SECTION R. Assessment Information

1. SIGNATURE OF PERSON COORDINATING / COMPLETING ASSESSMENT

1. **Signature (sign on above line)**

2. **Date assessment signed as complete**

☐☐ — ☐☐ — 2 0 ☐☐
Day Month Year

NOTES:

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