

	<h2 style="margin: 0;">Comprehensive Medical Assessment</h2> <h3 style="margin: 0;">Clinical Care 2.4</h3>
--	--

Allergies and Drug Intolerance:

Reason for Admission to an Aged Care Facility:

Current Medications: (Including prescription and non prescription)

SEE ATTACHED SHEET

Issues for consideration in medication management review:

- Currently taking 5 or more medications
- Significant medication changes in last 3 months
- Medication requiring therapeutic monitoring
- Adverse medication reaction
- Discharge from an acute facility in last 4 weeks

Other medication management required: _____

Resident Medication Management Review required yes no

Comments: _____

Comprehensive Medical Examination

Cardiovascular:

Pulse _____ BP _____

Respiratory:

Central Nervous System:

Comprehensive Medical Assessment Clinical Care 2.4

Gastrointestinal:

Urinary / Genital

Muscular / skeletal:

Endocrine:

Psychiatric:

Mood: _____

History of depression: _____

Functional Ability to Perform Activities of Daily Living:

Communication:	Effective	<input type="checkbox"/>	Impaired	<input type="checkbox"/>	Non verbal	<input type="checkbox"/>
Mobility:	Independent	<input type="checkbox"/>	Assistance/mobility aids	<input type="checkbox"/>	Immobile	<input type="checkbox"/>
	activity intolerance	<input type="checkbox"/>	Physiotherapy referral	<input type="checkbox"/>		
			required	<input type="checkbox"/>		
Eating:	Independent	<input type="checkbox"/>	Prompt and assist	<input type="checkbox"/>	Full feed	<input type="checkbox"/>
Dressing, showering, grooming:	Independent	<input type="checkbox"/>	Assist	<input type="checkbox"/>	Dependent	<input type="checkbox"/>
Toileting and continence:	Independent	<input type="checkbox"/>	Prompt and assist	<input type="checkbox"/>	Dependent/continence	<input type="checkbox"/>
					aids	<input type="checkbox"/>
Able to follow instructions:	Able	<input type="checkbox"/>	Simple	<input type="checkbox"/>	Variable	<input type="checkbox"/>
Sensory loss:	Hearing	<input type="checkbox"/>	Vision	<input type="checkbox"/>	Other	<input type="checkbox"/>

Behaviours of concern: physical verbal wandering other behaviours

Comments: _____

Cognitive Status: normal impaired variable severe loss dementia specific

Comments: _____

Comprehensive Medical Assessment Clinical Care 2.4

Height:	cms.	Weight:	kg.	BMI:	BSL:	m.mol:	Urinalysis
Oral Health:	teeth / dentures satisfactory <input type="checkbox"/>	poor dentition <input type="checkbox"/>	gum disease <input type="checkbox"/>	other <input type="checkbox"/>			
Comments: _____							
Weight:	normal <input type="checkbox"/>	underweight <input type="checkbox"/>	obese <input type="checkbox"/>	recent weight loss <input type="checkbox"/>	recent weight gain <input type="checkbox"/>		
Nutritional status:	satisfactory <input type="checkbox"/>	dietician referral required <input type="checkbox"/>					
Comments: _____							
Immunisation Status:	Influenza <input type="checkbox"/>	Tetanus <input type="checkbox"/>	Pneumococcal <input type="checkbox"/>				
Skin Integrity:	Peripheral vascular disease <input type="checkbox"/>	skin tears <input type="checkbox"/>	chronic wound <input type="checkbox"/>	rash <input type="checkbox"/>	bruising <input type="checkbox"/>		
	chronic pressure area <input type="checkbox"/>	other <input type="checkbox"/>					
Comments: _____							
Pain:	present <input type="checkbox"/>	chronic <input type="checkbox"/>	acute <input type="checkbox"/>	intermittent <input type="checkbox"/>			
Intensity:	mild <input type="checkbox"/>	moderate <input type="checkbox"/>	severe <input type="checkbox"/>				
Reason for Pain: _____							
Pain Management: _____							
Social History:							

Smoker <input type="checkbox"/>	Alcohol use <input type="checkbox"/>	Other <input type="checkbox"/>					
Additional Information / Summary							

Doctor Name:	Signature:	Date: