

**COMPREHENSIVE MEDICAL ASSESSMENT
SAMPLE FORM**

Use of a specific form to record the results of the CMA is not mandatory but the CMA should cover the matters listed below. The first page of this form can be used as a summary of the CMA.

Resident's Surname: _____ Resident's details (may be available from aged care home) eg Date of Birth: / / Pension No.	Other names: _____ Medicare No. DVA No. New or existing resident:
Aged Care Home: _____	Phone: _____
Next of Kin/Guardian Name: _____ Phone: _____	Advance care directive (or similar?) <input type="checkbox"/> No <input type="checkbox"/> Yes Enduring Medical Power of Attorney: <input type="checkbox"/> No <input type="checkbox"/> Yes
Has the resident had a previous CMA? <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes: Date of last CMA: / /	Resident consent Consent for a CMA obtained? <input type="checkbox"/> Yes Consent given by Resident <input type="checkbox"/> Representative <input type="checkbox"/> Date consent was given: / /
CMA Service Details Provided by Dr _____ Phone: _____ Is this the resident's usual doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No Date/s of service: _____	If doctor providing CMA is not the resident's usual doctor, has a report of the CMA been provided to the resident's usual doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSES/PROBLEMS

Principal diagnoses

Other significant health problems

_____	_____
_____	_____
_____	_____
_____	_____

IMMEDIATE ACTION

Cardiovascular system	Oral health
Respiratory system	Nutrition status
Pain	Dietary needs
Physical function	Skin integrity
Psychological function	Continence

Other:

ALLERGIES AND DRUG INTOLERANCE

_____	_____
_____	_____
_____	_____

CURRENT MEDICATION (including prescribed and non-prescribed medication) (drug chart/ Webster sheet can be attached)

_____	_____
_____	_____
_____	_____

Issues for consideration in medication management review:

OTHER SERVICES REQUIRED

EPC Care Plan	Y <input type="checkbox"/>	N <input type="checkbox"/>	EPC Case Conference	Y <input type="checkbox"/>	N <input type="checkbox"/>	Medication Management Review	Y <input type="checkbox"/>	N <input type="checkbox"/>
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Other: _____

Comments: _____

GP's Signature: _____	Date	/ /
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**COMPREHENSIVE MEDICAL ASSESSMENT
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Oral Health: Teeth Dentures Gums

Identified problems:

Nutrition Status: Weight _____ Height ____ BMI _____

Identified problems:

Dietary Needs: Identified problems:

Skin Integrity: Normal Abnormal (sores/lesions) Other

Identified problems:

Continence: Urinary Normal Abnormal Urine Test Normal Abnormal
(if indicated)
Faecal Normal Abnormal

Identified problems:

OTHER MEDICAL EXAMINATION AS RELEVANT TO RESIDENT

eg

Fitness to drive

Hearing

Vision

Smoking

Foot care

Sleep

Cardiovascular risk factors

Alcohol use

Other:

Identified problems: