

PERSONAL FUNCTIONAL ASSESSMENT

ALL QUESTIONS ON THIS FORM MUST BE COMPLETED. IF APPLICANT IS CURRENTLY IN A FACILITY, PLEASE HAVE LICENSED CAREGIVER COMPLETE THIS FORM. ATTACH COPY OF CURRENT MDS IF CURRENTLY IN A LONG-TERM CARE FACILITY.

For each area of your functioning listed below, please check or circle the description that best describes current ability. The word “assistance” means supervision, direction or personal assistance. For “Other Considerations”, please note any additional information you believe is pertinent. This will assist the Admissions Committee in determining the correct level of care. Unless otherwise directed, mark one box that is most representative of your abilities.

Name: _____ Date: _____

Major Health Problems: _____

Currently Living At: _____ Address: _____

_____ Telephone Number: _____

Name of Person Completing This Form: _____

Relationship To Applicant: _____

BATHING

I require: (check one)

- No assistance (get in and out of tub by myself, if tub is the usual means of bathing.)
- Some assistance in bathing.
- Total assistance in bathing.

Other considerations: _____

DRESSING - getting clothes from closets and drawers, including underclothes, outer garments, and using fasteners (including braces, if worn).

- I get clothes and get completely dressed without assistance.
- I receive some assistance in getting clothes and getting dressed.
- I receive total assistance in getting clothes and getting dressed.

Other considerations: _____

TOILETING - going to the "bathroom" for bowel and urine elimination, cleaning self after elimination, and arranging clothes.

- I require no assistance in toileting.
- I require assistance getting to and from the "bathroom", cleaning myself, in arranging clothes after elimination, or in use of night bedpan or commode.

Other considerations: _____

CONTINENCE

- I control urination completely by myself.
- I control bowel movements completely by myself.
- I occasionally lose control of: (If checked, circle one of the following)
 - a) bowel b) bladder c) both
- I **cannot** control urination.
- I **cannot** control bowel movements.
- I use adult incontinent protection such as Attends, Depends, or incontinent pads. (If checked, circle one of the following)
 - a) I care for them myself b) I need assistance with changing/cleaning
- I have a catheter. (If checked, circle one of the following)
 - a) indwelling b) external c) suprapubic
- I have a colostomy

Other considerations: _____

MOBILITY

- I can walk three blocks with or without assistive devices.
- I require assistive devices to walk. (Circle what applies)
 - a) cane b) walker c) crutches
- I cannot walk three blocks due to: (Please list)

- I use a wheelchair and can operate it independently.
- I use a wheelchair and require assistance to operate it.
- I have an electric wheelchair or scooter that I use.

Other considerations: _____

TRANSFERS

- I get in and out of bed, as well as in and out of a chair, without assistance.
- I require assistance to get in and out of bed or chair.

Other considerations: _____

EATING

- I eat without assistance.
- I feed myself with minor assistance.
- I receive total assistance in eating.
- I am fed by using a tube. If checked, circle one:
a) NG b)G-tube c)Other: _____

Other considerations: _____

OXYGEN

- Occasionally Continuous Do not use

Please check appropriate response for oxygen use: a) Receive at bedside b) Portable

Other considerations: _____

MEDICATIONS:

- I take my own medications Someone else gives me my medications

ORIENTATION: I am:

- Rarely confused or disoriented.
- Sometimes confused, disoriented and forgetful.
(To include functioning in familiar surroundings, but gets disoriented in new surroundings.)
- Totally confused and disoriented.
- I experience frequent periods of agitation such as yelling, hitting or throwing things.

Please circle the correct answer below:

1) Does this individual wander away and/or get lost? Yes No

If yes, how often? _____

How far? _____

2) Is he or she safe to be left alone at home for more than two hours? Yes No

3) Is this individual currently on a secured unit/facility? Yes No

4) Does this individual wear a wander guard? Yes No

5) Are restraints currently being used? Yes No State type and frequency:

PROSTHESIS

If you use prosthesis, please state type: _____

I can apply my own prosthesis: Yes No

Other conditions: _____

REHABILITATIVE SERVICES

Have you previously received or are you receiving rehabilitation treatment for a current physical condition? Yes No

Type of therapy received: _____

LOCATION

DATES

MENTAL HEALTH

Are you under a court commitment? Yes No
If yes, please circle appropriate type: Inpatient or Outpatient

Have you ever been hospitalized or received care in relation to mental health problems? Yes No

If yes, list name of doctor or agency: Date(s) Length of Stay

TOBACCO USE

- 1) Do you smoke cigarettes? Yes No
- 2) Do you chew tobacco or snuff? Yes No
- 3) If you smoke, are you a fire hazard when doing so? Yes No

Other considerations: _____

ALCOHOL/CHEMICAL DEPENDENCE

- I do not drink alcoholic beverages and/or use other chemical substances and have no history of problems with these substances.
- I have in the past, but not within the last year, and do not currently have problems with alcohol and/or chemical dependency.
- I currently have problems associated with alcohol and/or chemical dependency.

Have you consumed alcohol or non-prescription substances in the past 60 days? Yes No
If yes, how much? _____ How often? _____

Other considerations: _____

OTHER HEALTH CONSIDERATIONS

Presently I have:

- Pressure Ulcers
- Skin Rashes
- Injuries

Describe: _____

Other considerations: _____

Record the following past immunization dates and any reactions:

- 1. Tetanus/Diphtheria Date: _____ Reaction: _____
- 2. Pneumovax Date: _____ Reaction: _____
- 3. Influenza Date: _____ Reaction: _____
- 4. Mantoux Date: _____ Reaction: _____
- 5. Hepatitis B Date: _____ Reaction: _____

Answer the following questions: (Circle yes or no) If yes, please explain, including dates.

- 6. Do you have allergies, especially to egg, poultry or specific immunizations? Yes No Date: _____
- 7. Have you had T.B. (tuberculosis?) Yes No Date: _____
- 8. Have you had close contact with anyone who has had T.B.? Yes No Date: _____
- 9. Do you have night sweats? Yes No Date: _____
- 10. Do you cough up bloody sputum? Yes No Date: _____
- 11. Have you had sudden unexplained weight loss? Yes No Date: _____
- 12. Have you had a T.B. skin test? Yes No Date: _____
- 13. Did you have a reaction? Yes No Date: _____
- 14. Do you presently have or have you had a history of infection(s) and/or communicable disease(s)? Yes No Date: _____
- 15. Do you presently have or have you had a history of having MRSA or VRE or any other resistive diseases? Yes No Date: _____

Please include the following information (indicate disease or immunization and date).

	<u>Disease</u>		<u>Immunization</u>		
Mumps	Yes	No	Yes	No	Date: _____
Pertussis (Whooping Cough)	Yes	No	Yes	No	Date: _____
German Measles	Yes	No	Yes	No	Date: _____
Red Measles	Yes	No	Yes	No	Date: _____
Smallpox	Yes	No	Yes	No	Date: _____
Chicken Pox	Yes	No	Yes	No	Date: _____
Polio	Yes	No	Yes	No	Date: _____

