Iowa Veterans Home
1301 Summit Street
Marshalltown, Iowa 50158

PERSONAL FUNCTIONAL ASSESSMENT

ALL INFORMATION REQUESTED ON THIS FORM IS REQUIRED except for sections titled other considerations and please comment.

IF YOUR ARE CURRENTLY IN A FACILITY, PLEASE HAVE LICENSED CAREGIVER COMPLETE THIS FORM. IF CURRENTLY IN A LONG-TERM CARE FACILITY, ATTACH COPY OF CURRENT MDS; MAR w/ PRN's; PASRR AND FACESHEET.

For each area of your functioning listed on the following pages, please mark the description which best describes your current ability. The word "assistance" means supervision, direction or personal assistance. For "Other Considerations", please note any additional information which you believe is pertinent and will assist the Admissions Committee in determining the correct level of care. Unless otherwise directed, mark the one box that is most representative of your abilities. Attach additional sheets as necessary.

Name:_____ Date: _____

Currently Living At:_____

Address:_____

_____

Telephone Number(s):_____

Name of Person Completing This Form: _____

Relationship to Applicant:_____

BATHING

- ☐ No assistance needed. I get in and out of shower and/or tub by myself (if tub is the usual means of bathing).
- ☐ Assistance with set-up/cueing only and can bathe myself.
- ☐ Some assistance in bathing. (*Please explain assistance needed below).*
- ☐ Total assistance in bathing.

FREQUENCY (mark one of the following)

☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Other _____

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 get clothes and get completely dressed with adaptive devices. (*Please explain below.)*
- ☐ I get completely dressed by myself once clothes are set out.
- ☐ I receive some assistance in getting clothes and getting dressed. (*Please explain assistance needed below.)*
- ☐ I receive total assistance in getting clothes and getting dressed.

Other considerations: _____

_____

GROOMING: HAIR

- ☐ I get out needed items and can comb/brush my hair myself.
- ☐ I can brush/comb my hair myself but need set-up/cueing to complete.
- ☐ I need total assistance with brushing/combing my hair.

SHAVING

- ☐ I get out needed items and can shave myself.
- ☐ I can shave myself but need set-up/cueing to complete.
- ☐ I need total assistance with shaving.
- ☐ I typically use an electric razor.

ORAL HYGEINE

- ☐ I get out needed items and clean my teeth/dentures myself.
- ☐ I can clean my teeth/dentures myself but need set-up/cueing to complete.
- ☐ I need total assistance with cleaning my teeth/dentures.

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 in getting to and from the "bathroom" only.
- ☐ I require assistance getting to and from the "bathroom", cleaning myself and/or in arranging clothes after elimination or in use of night bedpan or commode.

Other considerations: _____

_____

CONTINENCE (Choose all that apply)

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

Other considerations: _____

_____

EATING

- ☐ I eat without assistance.
- ☐ I feed myself but need my meal set-up or adaptive devices.
- ☐ I feed myself with minor assistance. (*Please explain below.)*
- ☐ I receive total assistance in eating.
- ☐ I am fed by using a tube. (If checked, mark one of the following)
  - ☐ NG ☐ G-tube ☐ Other:

Other considerations: _____

_____

DIETARY CONSIDERATIONS

Height: _____ Weight: _____

What type of diet is recommended? ☐ Regular ☐ Diabetic ☐ Renal

Texture recommendations? ☐ Minced ☐ Pureed ☐ Thickened

Do you comply with your diet recommendations? ☐ Yes ☐ No

Do you have difficulty swallowing and/or chewing food? ☐ Yes ☐ No

Do you have difficulty swallowing liquids? ☐ Yes ☐ No

Typical appetite? ☐ Good ☐ Fair ☐ Poor

Other considerations: _____

_____

OXYGEN

☐ Occasional ☐ Continuous ☐ Do not use

☐ CPAP ☐ Other

Please mark the appropriate response for oxygen use: ☐ Receive at bedside ☐ Portable

Are you compliant with your oxygen use? ☐ Yes ☐ No

Do you own your oxygen equipment? ☐ Yes ☐ No

If yes, who issued the equipment? Medicare ☐ DVA ☐ Personal Purchase ☐

Other considerations: _____

_____

MEDICATIONS (Choose all that apply)

- ☐ I take my own medications.
- ☐ I take my own medications after someone else sets them up.
- ☐ Someone else gives me my medications.
- ☐ I receive medications by injection.
- ☐ I receive my medications crushed.

Other considerations: _____

_____

ORIENTATION (**Choose all that apply)**

- ☐ Never confused or disoriented.
- ☐ 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 explain: _____

_____

_____

Please mark the appropriate answers below:

1. Do you wander away and/or get lost? ☐ Yes ☐ No
   If yes, how often? _____ Please explain the circumstances: _____

   _____

   _____
2. Are you safe to be left alone at home *alone* for more than two hours? ☐ Yes ☐ No
3. Are you currently in a secured facility? ☐ Yes ☐ No
4. Are you currently on a secured unit? ☐ Yes ☐ No
5. Do you wear a WanderGuard? ☐ Yes ☐ No
6. Are restraints currently being used? ☐ Yes ☐ No
   If yes, state type and frequency: _____

   _____

MOBILITY: INDEPENDENT

☐ I can walk two blocks with or without assistive devices independently.

☐ I require assistive devices to walk independently. (Mark all that apply)

☐ cane ☐ walker ☐ crutches

Other considerations: _____

_____

ASSISTED (Choose all that apply)

☐ I use a manual wheelchair and can operate it independently.

☐ I use a manual wheelchair and require assistance to operate it.

☐ I use a walker and need assistance of one person to ambulate

☐ I use a walker and need assistance of more than one person to ambulate.

☐ I have a power mobility device (electric wheelchair or scooter) that I use.

Other considerations: _____

_____

EQUIPMENT:

Do you use a cushion for your wheelchair? ☐ Yes ☐ No

Do you own your mobility equipment? ☐ Yes ☐ No

If yes, who issued the equipment? Medicare ☐ DVA ☐ Personal Purchase ☐

Other considerations: _____

_____

TRANSFERS

☐ I get in and out of bed as well as in and out of a chair, without assistance.

☐ I require assistance from one person to get in and out of bed or chair.

☐ I require assistance from more than one person to get in and out of bed or chair.

☐ I require use of a gait belt to get in or out of bed or chair.

☐ I require a lift to get in and out of bed or chair. Type of lift needed:

Ceiling Lift ☐ Stand Lift ☐ Hoyer Lift ☐

☐ I can turn from side to side when in bed without assistance.

☐ I need assistance to turn from side to side when in bed.

Other considerations: _____

_____

FALL HISTORY

Have you had any recent falls? ☐ Yes ☐ No If yes, please explain the circumstances surrounding each fall: _____

_____

_____

If yes, how many falls have you had in the last 3 months? _____

Are these falls a change in baseline behavior? ☐ Yes ☐ No

When was your last fall? _____

PROSTHESIS

If you use prosthesis, please state type: _____

I can apply my own prosthesis: ☐ Yes ☐ No

Other considerations: _____

_____

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 mark appropriate type: ☐ Inpatient ☐ 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 or cigars? ☐ Yes ☐ No
2) Do you chew tobacco or use snuff? ☐ Yes ☐ No
3) If you smoke, are you a fire hazard when doing so? ☐ Yes ☐ No

If yes, please explain: _____

_____

Other considerations: _____

_____

ALCOHOL/CHEMICAL DEPENDENCE

☐ I do not drink alcoholic beverages nor do I use other chemical substances and have no history of problems with these substances.

☐ I occasionally drink alcoholic beverages, but never to excess 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, what and how much?_____How often?_____

Please list treatment programs attended/completed and date(s):

_____

_____

Other considerations: _____

_____

OTHER HEALTH CONSIDERATIONS

Presently I have: ☐ Pressure Ulcers ☐ Skin Rashes ☐ Injuries

Please describe: _____

_____

_____

Other considerations: _____

_____

Record the following past immunization dates and any reactions. Provide a copy of immunization, if available.

1. Diphtheria-Pertussis-Tetanus (DPT) Date: _____ Reaction: _____
2. Pneumovax Date: _____ Reaction: _____
3. Influenza Date: _____ Reaction: _____
4. Mantoux Date: _____ Reaction: _____
5. Hepatitis B Date: _____ Reaction: _____

Please answer the following questions to the best of your ability: (Mark yes or no) If yes, please explain, including dates.

6.	Do you have allergies, especially to eggs, poultry or specific immunizations?	☐	Yes	☐	No	Date: _____
7.	Have you had TB (tuberculosis?)	☐	Yes	☐	No	Date: _____
8.	Have you had close contact with anyone who has had TB?	☐	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 TB 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 disease?	☐	Yes	☐	No	Date: _____

Please complete the following information to the best of your ability.

Illness	Disease				Immunization				
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: _____

THIS SPACE PROVIDED FOR ANY ADDITIONAL COMMENTS/INFORMATION YOU MAY HAVE:

Name: _____