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/ PRNs; 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).
- ☐ Cueing only. Can bathe self
- ☐ Assistance with set-up. Please explain set up required.
  ____
  ____
- ☐ Some assistance in bathing. *Please explain assistance required.*
  ____
  ____
- ☐ 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 my clothes and get completely dressed without assistance.
- ☐ I get my clothes and get completely dressed with adaptive devices. (*Please explain below.)*
- ☐ I get completely dressed by myself once clothes are set out.
- ☐ I require cueing to complete dressing. Please explain cueing required.
  ____
  ____
- ☐ 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: ____________________
____

 Name: ____________________

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.
- ☐ I need cueing to complete. Please explain cueing required.
  ____
  ____
- ☐ 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.
- ☐ I need cueing to complete. Please explain cueing required
  ____
  ____
- ☐ I need total assistance with shaving.
- ☐ I typically use an electric razor.

ORAL HYGIENE

- ☐ I get out needed items and clean my teeth/dentures myself.
- ☐ I can clean my teeth/dentures myself but need set-up.
- ☐ I can clean my teeth/dentures myself but need cueing to complete. Please explain cueing required
  ____
  ____
  ____
- ☐ 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: ______________________________

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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: ______________________________

____

____

ORIENTATION (**Choose all that apply)**

☐ Never confused or disoriented.

☐ Rarely confused or disoriented. Describe confusion.
____

☐ Sometimes confused, disoriented and forgetful. (To include functioning in familiar surroundings, but gets disoriented in new surroundings.) Describe confusion.
____

☐ Totally confused and disoriented. Describe confusion.
____

☐ I experience frequent periods of agitation such as yelling, hitting or throwing things. Explanation required: _______________

____

____

____

____

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 secure memory care area? ☐ Yes ☐ No
4. Do you wear a WanderGuard bracelet? ☐ Yes ☐ No
   ****If using a WanderGuard does the individual check doors or in some other way try to exit the facility? ☐ Yes ☐ No**
5. Are restraints currently being used? ☐ Yes ☐ No
   If yes, state type and frequency: _______________
   ____
   ____
   ____
   ____
   ____

 Name: _______________

FOOD & NUTRITION SERVICES:

Height: ____________ Weight: ___________lbs. My usual weight is: ________lbs.

I have experienced significant changes in weight in the past 6 months: ☐ Yes ☐ No

If yes, describe: ____

____

I have a food allergy or intolerance: ☐ Yes (list below) ☐ No

Food allergies (if any): ____

Food intolerance (if any): ____

I have special dietary needs related to my religion, culture or ethnicity: ☐ Yes ☐ No

If yes, please describe: ____

____

IMPORTANT NOTICE: IVH does not offer holistic and/or organic foods and drinks. Residents may purchase these at their own expense if they wish

My usual diet(s):

☐ Regular ☐ Heart Healthy

☐ Diabetic (Small Portions diet available)

☐ Renal/Dialysis (Modified Renal diet available)

☐ Pureed ☐ Thickened Liquids ☐ Tube feeding: ______________________

I have difficulty swallowing and/or chewing? ☐ Yes ☐ No

My appetite is generally: ☐ Good ☐ Fair ☐ Poor

I am able to feed myself food & drinks: ☐ Always ☐ Sometimes ☐ Not usually or never

I use adaptive tools at meals (e.g. weighted silverware, plate guard, etc.) ☐ Yes ☐ No

If yes, list adaptive tools: ____

Other considerations: ____

____

 Name: ______________________________

MEDICATIONS **(Choose all that apply)**

- ☐ I take my own medications.
- ☐ I take my own medications after someone else sets them up.
- ☐ Need reminders to take medications. What mechanism is used to remind you to take medications?
- ☐ Someone else gives me my medications.
- ☐ I receive medications by injection.
- ☐ I receive my medications crushed.

Other considerations: ____

____

OXYGEN

☐	Occasional Liter flow? ________ How often used? ________	☐	Continuous Liter Flow? ________	☐	Do not use
☐	CPAP/BiPAP	☐	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: ____

____

 Name: ______________________

MOBILITY

- ☐ 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

  Distance able to walk with the use of assistive devices? __________
- ☐ I use a manual wheelchair and can operate it independently. Distance able to wheel manual wheelchair without assist? ____________
- ☐ 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. Please see supplement related to power mobility devices at the Iowa Veterans Home.

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 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: ______________________________

☐ Eyeglasses ☐ Hearing aids ☐ Dentures ☐ Other ______________

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

____

____

____

____

____

____

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 chemical 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: ____

____

TOBACCO USE

1) Do you smoke cigarettes, e-cigarettes, cigars or vape? ☐ Yes ☐ No

2) Do you chew tobacco or use snuff? ☐ Yes ☐ No

OTHER HEALTH CONSIDERATIONS

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

Please describe: ____

____

____

Other considerations: ____

____

 Name: ___________________________________

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

	Immunization	Date	Reaction
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.

	Question					
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: __________

Name: ____

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

Name: ______________________