AGED CARE ASSISTANCE

HEALTH CARE NEEDS LIST

Tick the columns that best describe the amount of assistance you need with each task of everyday living. There is space for you to write anything relevant to the subject.
Circle Yes / No where applicable or where NA (not applicable) is relevant.
Take this document to appointments with your GP, health care assessors and potential service providers when visiting them to discuss service support.

CARE NEEDS	No help required	Help to set up then OK by self	Requires a person to assist or standby for supervision	Requires full physical assistance	
EATING (NA- has feed tube)					Uses special utensils **Y / N**

Do you prepare your own meals or use MOW?
Weight – Stable / unstable. If so, describe.

WALKING (NA – Cannot walk)					Uses walking aid **Y / N** What kind?

Do you have trouble getting in and out of a chair or car? Describe.

BATHING / SHOWER					Uses shower chair **Y / N**
USING A TOILET					Uses toilet raiser **Y / N** Uses bottle/pan **Y / N**
	No Incontinence	Occasional – a few times a week	Daily incontinence	Nearly always incontinent	
URINARY					Wears pads

CONTINENCE (NA – has catheter)					**Y / N**
BOWEL CONTINENCE (NA –has colostomy / ileostomy)					Wears pads **Y / N**
	No memory issues	Occasional forgetfulness a few times/week	Daily difficulty with memory recall	Frequent confusion causing emotional and behaviour issues	
MEMORY					Has Dementia diagnosis **Y / N**
	Never	Occasional – a few times/week	Daily	Frequent issues to manage throughout a day	
RISKY BEHAVIOURS Circle which is applicable - Restless, Wandering, Verbal outbursts, Cant accept reason, Physical Aggression, Irritable moods, Night disturbance					

ANY SUDDEN HEALTH CHANGES RECENTLY?_____

_____

MAJOR DIAGNOSIS: (Circle)

ATHEROSCLEROSIS (Hardened Arteries)	ARTHRITIS	CARDIAC FAILURE (CCF)
ASTHMA	CHRONIC AIRWAYS DISEASE	CANCER (state type)_____
DEPRESSION	DIABETES Diet/Tablet controlled	DIABETES Insulin controlled
BI-POLAR ILLNESS	SCHIZOPHRENIA	PARKINSON'S DISEASE
MOTOR NEURONE DISEASE	HAS HAD CEREBROVASCULAR ACCIDENT (CVA) or experiences TRANS ISCHEMIA	

OTHER (state) _____

MEDICATIONS

Tick appropriate answer

☐I manage my medications myself and don't require any help when deciding how to take them.

☐I use a dispensing device which my pharmacist fills with my medications / a family member fills with my medications (circle who helps)
I don't have any problems with using this kind of system.

☐ I use a dispensing device which my pharmacist fills with my medications / a family member fills with my medications (circle who helps)
I don't have any problems with using this kind of system.

☐Someone else gives me my medications when they are due.

WRITE HERE THE MEDICATIONS AS YOU ARE TAKING THEM NOW

NAME OF MEDICATION	DOSE OF EACH SINGLE TABLET DISPENSED BY THE PHARMACIST IN GRAM (gm) MILLIGRAM (mg) OR MICROGRAM (mcg)	THE NUMBER OF GRAMS, MILLIGRAMS OR MICROGRAMS YOU TAKE	HOW OFTEN DO YOU TAKE THIS DOSE REGULARLY	If you take this tablet occasionally or only when necessary, describe how often and how you decide an extra dose is required
IE Lasix	40mg	20mg	Half a tablet breakfast and lunch time	If my rings are tight I take a full tablet instead of just a half

GENERAL HEALTHCARE

Are you receiving home care services Y / N If yes, name and contact details and description of services received._____

_____

Have you been in hospital in the past 3 months Y / N If yes, reason_____

Can you manage your bills/finances? Y / N If no, who helps_____

In the past 4 weeks have you felt nervous, depressed or lonely? Y / N If yes, what are you most concerned about_____

Are there hazards or safety risks at home? Y / N If yes, describe_____

COMPLEX HEALTH CARE

Do you have any of the following health care needs? (Tick)

☐ Blood sugar testing – How often? _____

☐ Blood Pressure monitoring – How often?_____

☐ Chronic Pain – Where? _____

☐ Balance / Walking issues- Describe_____

☐ A fall in the past 3 months – Was there a cause, Describe_____

☐ A swallowing or choking risk – Describe_____

☐ Wound care – Describe_____

☐ Hearing deficit - Describe_____

☐ Sight deficit – Describe_____

☐ Chronic Infection ie MRSA, Hepatitis C – State _____

☐ Stoma Care required – State what kind_____

☐ Breathing Assistance used – Circle: Oxygen, CPAP machine. How often_____

☐ Tracheostomy care required - Describe_____

☐ Regular use of suppositories, enemas or injections – Describe_____

☐ I have a life limiting illness and require Palliative Care

LEGAL REPRESENTATIVES / FORMAL ADVOCATES

Tick which legal directives you have (Some organisations will require a copy of these documents when you accept their services for their confidential records)

☐ A Will
☐ Power of Attorney (Financial)
☐ Enduring Power of Guardianship (Financial & Medical)
☐ Schedule 1 Palliative Care Act (Medical Power of Attorney)
☐ Schedule 2 Palliative Care Act (Anticipatory Directive)
☐ Advanced Care Directive (Medical & Care Directives)
☐ Guardianship Board Order (Financial Management / Treatment Order) Please describe_____
☐ Other – Describe_____

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