KleerView Healthcare Solutions, LLC

PERSONAL/COMPANION CARE HOME ASSESSMENT

This form may be completed by the client/family when providing companion care. Some fields may not comply for companion care services. PLEASE DO NOT COMPLETE THIS FORM IF YOU/YOUR LOVED ARE REQUIRING PERSONAL CARE. Please leave them blank or write N/A. If we determine any missing information necessary, we will alert the client/family. We encourage you to complete this form with as much detail as possible to assist us in delivering the highest quality of service.

Date of Screening: _____

Type of Assessment: ☐ Initial Admission ☐ Annual ☐ Significant Change

Date of this assessment: _____ Date of Admission: _____

Client Name: _____ Date of Birth: _____

SUPPORTS

Formal Supports

Support	Name	Address	Phone Number
Primary Physician			
Dentist			
Case Manager			
Other (specify)			

Family/Friend Supports

Name	Relationship	Address	Phone Number

MEDICAL INFORMATION

Diagnosis (from Client Medical Evaluation): (check all applicable)

☐ None Known ☐ Mental Illness ☐ Mental Retardation
☐ Dementia* ☐ Other (specify) _____

*Stage of Dementia/ observations: _____
_____
_____

History of falls/ safety issues: _____
_____
_____
_____
_____

Check all that apply:

- ☐ Non-self-care gastrointestinal feedings*
- ☐ Decubitus ulcers (bed sores)*
- ☐ Naso-gastric feedings *
- ☐ Intravenous fluid/medications*
- ☐ Non-self-care oxygen*
- ☐ Oxygen Monitoring
- ☐ Catheter care

*Date/Health Care Source of Referral for medical follow-up _____

- ☐ Incontinence of Bladder
- ☐ Incontinence of bowel
- ☐ Tracheotomy monitoring
- ☐ Blood pressure monitoring
- ☐ Non-self-care inhalation therapy
- ☐ Colostomy monitoring
- ☐ Special skin care precautions
- ☐ Diabetes Care
- ☐ Other (specify) _____

ACTIVITIES OF DAILY LIVING	Code*
Eating	
Drinking	
Transferring in/out of bed/chair	
Toileting (bowel)	
Toileting (bladder)	
Personal hygiene - bathing	
Personal hygiene - grooming	
Personal hygiene - dressing / undressing	
Securing health care	
Managing health care	
Turning and positioning in bed/chair	

INSTRUMENTAL ACTIVITIES OF DAILY LIVING:	Code*
Personal laundry	
Shopping	
Securing and using transportation	
Managing finances	
Using the telephone	
Making and keeping appointments	
Caring for personal possessions	
Writing correspondence	
Engaging in social and leisure activities	
Using a prosthetic device	
Obtaining clean, seasonal clothing	
Other (specify)	
Other (specify)	

* CODES:
A Independent with or without assistive devices
B Requires prompting or cueing to complete
C Requires physical assistance to complete
D Requires full physical assistance
E N/A

COMMUNICATION

Ability to Hear

- ☐ No impairment
- ☐ No hearing even with device
- ☐ Impairment evident but does not interfere with everyday functioning
- ☐ Impairment interferes with everyday functioning
- ☐ Minimal hearing even with device.
- ☐ Hears with device: _____

Ability to See

- ☐ No impairment
- ☐ No vision even with device
- ☐ Impairment evident but does not interfere with everyday functioning
- ☐ Impairment interferes with everyday functioning
- ☐ Minimal vision even with device
- ☐ Sees with device: _____

Understanding instruction and what is said

- ☐ No impairment
- ☐ Impairment evident but does not interfere with everyday functioning
- ☐ Impairment interferes with everyday communication or is significant enough to require the use of an alternate mode of communication. Please specify _____ _____
- ☐ Minimal communication ability with or without the use of an alternative mode of communication: or no communication ability

Memory

- ☐ No impairment
- ☐ Impaired on clinical exam but does interfere with everyday
- ☐ communication Impairment interferes with everyday
- ☐ Minimal or no memory functioning

Medications

(check all applicable)

- ☐ Can self-administer medications with no assistance from others
- ☐ Can self-administer medication with assistance to store medications in a secure place
- ☐ Can self-administer medications with assistance in remembering schedule
- ☐ Can self-administer medications with assistance in offering medications at prescribed times
- ☐ Can self-administer medications with assistance opening container or locked storage area

OR

- ☐ Cannot self-administer medications

Mobility Aids

☐ None ☐ Walker ☐ Cane
☐ Wheelchair ☐ Braces/Prostheses ☐ Other (specify) _____

(check all applicable)

☐ Unable to move from one location to another without physical assistance from others
☐ Unable to move from one location to another without oral prompting from others
☐ Difficulty understanding and following oral directions in the event of an emergency
☐ Independently mobile with ambulation device
☐ Walks without assistance

CHOOSE ONE:

Client who has a mobility need

☐ A Client who is unable to move from one location to another, has difficulty in understanding and carrying out instructions without the continued full assistance of other individuals or is incapable of independently operating an ambulation device, such as a wheelchair, prosthesis, walker or cane to exit a building.

Client who does not have a mobility need

☐ A Client who is physically and mentally capable of vacating the personal care home on the Client's own power or with limited physical or oral assistance in the case of an emergency, including the capability to ascend or descend stairs if present on the exit path. (Physical assistance means assistance in getting to one's feet or into a wheelchair, walker or prosthetic device. Oral assistance means giving instructions to assist the Client in vacating the personal care home.) The term includes an individual who is able to effectively operate an ambulation device required for moving from one place to another, and able to understand and carry out instructions for vacating the personal care home.

SUPERVISION

Identify the Client's needs for supervision (take into account physical health, mental health and behavior).

☐ No supervision needed
☐ Occasional checking needed
☐ Needs 24-hour supervision
☐ Needs supervision only at certain times of day or during certain activities (specify activities / times)

SPECIAL HEALTH OR DIETARY NEEDS

Please list any special health or dietary needs.

COGNITIVE

Is the client able to tell you:

The correct date?	☐ Yes	☐ No
The correct time?	☐ Yes	☐ No
Who they are?	☐ Yes	☐ No

Irritability

- ☐ No problem
- ☐ Current problem, but does not interfere with everyday functioning
- ☐ Problem interferes with everyday functioning
- ☐ Severe problem that requires intervention

Judgment

- ☐ No impairment
- ☐ Impaired on clinical exam but does not interfere with everyday communication
- ☐ Impairment interferes with everyday
- ☐ Minimal ability to generate appropriate options

Aggression

- ☐ No problem
- ☐ Current problem but does not interfere with everyday functioning
- ☐ Problem interferes with everyday functioning
- ☐ Severe problem that requires intervention

Anxiety

- ☐ No problem/ socially appropriate
- ☐ Current problem but does not interfere with everyday functioning
- ☐ Problem interferes with everyday functioning
- ☐ Severe problem that requires intervention

Agitation

- ☐ No problem
- ☐ Current problem but does not interfere with everyday functioning
- ☐ Problem interferes with everyday functioning
- ☐ Severe problem that requires intervention

Depression (withdrawal, lack of enjoyment, tearfulness)

- ☐ No problem
- ☐ Current problem but does not interfere with everyday functioning
- ☐ Problem interferes with everyday functioning
- ☐ Severe problem that requires intervention

Wandering

- ☐ No problem
- ☐ Current problem but does not interfere with every day functioning
- ☐ Problem interferes with every day functioning
- ☐ Severe problem that requires intervention

Hallucination/delusions/paranoia

- ☐ No problem
- ☐ Current problem but does not interfere with every day functioning
- ☐ Problem interferes with every day functioning
- ☐ Severe problem that requires intervention

REFERRALS NEEDED (source of care/frequency) : If Applicable

Medical	Urology	Mental Health Services
Dental	Gynecology	Behavioral Care Sciences
Vision	Visiting Nurses	Mental Retardation Services
Hearing	Wellness Program	VA Services
Podiatry	Psychological Services	Transportation Services
Cardiology	Case Management	Speech Therapy
Pulmonary	Occupational Therapy	Physical Therapy
Other (specify):		

PREFERENCES

What activities does the Client enjoy (such as hobbies or interests)? _____

What leisure activities does the Client enjoy?_____

Does the Client like to go out and do things with other people?_____

What is the Client's religious affiliation, if any? Does the Client wish to participate in religious practices or services?_____

What does the Client dislike?_____

Are there any situations or activities that are disturbing or agitating for the Client?_____

APPROPRIATENESS OF SERVICES

Do the placement and services remain adequate for the Client? ☐ Yes ☐ No
If no, explain: _____

Is there a need for additional services for this Client? ☐ Yes ☐ No
If yes, referrals made: _____

DOCUMENTATION OF PARTICIPATION

☐ Client Signature (if participated in development): _____

☐ Client's family member:

Name:

Address:

Telephone:

Signature (if participated in development):

☐ Client's designated person

Name:

Address:

Telephone:

Signature (if participated in development):

☐ Other

Name:

Address:

Telephone:

Signature (if participated in development):

Staff Name/Title _____

Staff Signature _____