Submit

BETTER OUTCOMES HOME CARE
PRE ASSESSMENT FORM

Date: *Name of Contact:* *Phone:*

Name of Person Receiving Care:

Address: Apt #:

Care Goals (What are you wanting the care to accomplish):

What Days and Times:

Mon: _____

Tues: _____

Weds: _____

Thurs: _____

Fri: _____

Sat: _____

Sun: _____

Gender: {Select One} Ethnicity: {Select One}

Date of Birth: _____ Height: _____ Weight: _____

Marital Status: {Select One} Spouse Name: _____

Lives With: _____ Relation: _____

DNR: ☐ Yes ☐ No ☐ Unknown Advanced Directives: ☐ Yes ☐ No

Doctor(s) Contact Information

Veteran: ☐ Yes ☐ No

Long Term Care INS: ☐ Yes ☐ No

Past Profession:

INS Agent Contact Information:

Name:

Phone:

Email:

What area's of care assistance would you like (Check All That Apply):

Activities of Daily Living (ADL's):

☐ Ambulation ☐ Eating

☐ Transferring ☐ Toileting

☐ Bathing

☐ Continence

☐ Dressing/Grooming

Instrumental Activities of Daily Living (iADL's):

☐ Housework ☐ Preparing Meals

☐ Laundry ☐ Shopping

☐ Medication ☐ Using Telephone

☐ Money/Bills ☐ Companionship

☐ Pet Care ☐ Transportation

Notes:

Hearing: ☐ Good ☐ Poor ☐ Deaf ☐ Aid (if applicable)

Vision: ☐ Good ☐ Poor ☐ Blind ☐ Glasses ☐ Contacts

Speech: ☐ Good ☐ Poor ☐ None

☐ Client Car

☐ Caregiver Car

Other: ☐ Smoker ☐ Sensitive to smell ☐ On oxygen ☐ Colostomy bag ☐ Feeding tube

Allergies: _____

Wears Briefs: ☐ Protection ☐ Full Incontinence Incontinence: ☐ Urination ☐ Bowels

☐ Constipation ☐ Diarrhea ☐ Frequent Urination

Ambulation: ☐ Cane ☐ Walker ☐ Wheel Chair ☐ Lift-chair ☐ Scooter ☐ Fall Risk

☐ Poor Balance ☐ Use of Arms/Hands: ☐ Left ☐ Right

Currently Receiving Services From:

☐ Home-Health ☐ Hospice ☐ Home Care ☐ None

Name and contact information for any of the above listed services:

Home-Health: Hospice: Home Care:

Medical Condition:

- ☐ Dementia
- ☐ Arthritis
- ☐ Neuropathy
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Lou Gehrig's
- ☐ Lewy Body
- ☐ Kidney and bladder
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Osteoporosis
- ☐ Cardiovascular disease
- ☐ Lung disease
- ☐ Respiratory disease
- ☐ Asthma
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Other: _____

Mental Behaviors:

- ☐ Depression
- ☐ Mood changes
- ☐ Short term memory
- ☐ Speaking/conversing
- ☐ Anxiety
- ☐ Paranoia
- ☐ Repetition
- ☐ Completing task
- ☐ Lethargy
- ☐ Other: _____

History of:

- ☐ Stroke
- ☐ Heart Attack
- ☐ Seizures
- ☐ Cancer
- ☐ Fluid Retention
- ☐ Difficulty Breathing
- ☐ Skin Sores
- ☐ High Blood Pressure
- ☐ Bone/Joint Injury
- ☐ Rotator Cuff Injury

Medication and Supplements

Needs Med/Supplement Reminders: ☐ Yes ☐ No

How many times per day: _____

Who Manages meds/sups: _____

Separate schedule sheet: ☐ Yes ☐ No

Med/Sup set up in pill boxes: ☐ Yes ☐ No

Notes:

Daily Routine:

Morning: _____

Afternoon: _____

Evening: _____

Notes: _____

Assistance with meals: ☐ Cooking ☐ Preparation ☐ Feeding Appetite: ☐ Poor ☐ Good ☐ Encourage

Diet: ☐ Poor ☐ Encourage Nutrition ☐ Good Special Diet: _____

Times: Breakfast _____ Lunch _____ Dinner _____ Snacks _____

Other: ☐ Swallowing Issues ☐ Encourage Liquids ☐ Dentures

Favorite Foods: Breakfast: _____ Lunch: _____

Snack: _____ Dinner: _____ Dessert: _____

Activities at home (e.g. reading, board games, hobbies, music):

_____

Activities away from home (parks, gardens, outings, lunches, etc.): Pet(s): ☐ Yes ☐ No ☐ Cat ☐ Dog

Favorite restaurants/shops:

Family/Friends/Neighbors: