

HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

Practice
Record

Aboriginal & Torres Strait Islander: Item 715

Others: Item 701 Item 703 Item 705 Item 707

PATIENT NAME

DOB

Male Female

Name & contact
details of carer

Medical Practitioner _____

Medical record/file No. _____

Is this patient a carer? Yes No

This is the only health assessment the patient
has undertaken in the last 12 months Yes No

Health Assessment at Practice

This is a review of a Health Assessment
undertaken: / /

Home Visit

HISTORY

COMMUNITY / HEALTH SERVICES

1 Ask the patient "in general, would you say
your health is..."
Excellent
Very good
Good
Fair
Poor

2 Current health problems /
relevant family history

3 Ask the patient "Are you seeing or have
you seen any other GP/specialist/other
health worker in the last 6 months?"
eg

- Aboriginal health worker
- Audiologist
- Community nursing
- Continence Adviser
- Daycare
- Dental
- Dietician
- Education providers
- HACC — home help
- Meals on wheels
- Occupational therapist
- Optometrist

- Orthoptist
- 1:1 Orthotist
- Pharmacist
- Physiotherapy
- Podiatry
- Prosthetist
- Psychologist
- Registered nurse
- Respite care
- Self help provider
- Social worker
- Specialist
- Speech therapist

other services/specialists in
last 6 months

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SMOKING / ALCOHOL

4 Smoking

- Never smoked
- Has quit smoking (when)
- Currently smokes
- Wishes to quit

Comments

5 Alcohol Consumption

Comments

Consider AUDIT, CAGE or other scales



PHYSICAL ACTIVITY

30 minutes a day, most days

N

EXAMINATION

7 Weight

kg

8 Height

m

9 BMI

10 BP/Pulses

Systolic BP mm/Hg

Diastolic BP mm/Hg

Pulse regular

Pulse irregular 1=1

Pulse rate

Comments

Y

Consider check for postural hypotension

N D

worm;

11 Comments

12 Oral Health

Comments eg teeth, gums, dentures

13 Feet

Problems with one or both feet?

N

Do you exercise at least

Comments

14 Vision

Acuity (with glasses)

Comments

15 Hearing

a Whisper test

Heard
Not heard

Comments

b Hearing aid

NIA
Adequate
Poor

c Check ear canals

Normal
Abnormal

16 Fit to drive

Comments

yo ND

Refer AustRoads Guidelines

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NUTRITION f DEPENDENCE / SOCIAL SUPPORT

17 Nutrition

These questions may not apply to all eg those with particular conditions or lifestyles

	score
Do you have an illness or condition that made you change the kind and/or amount of food you eat?	yes 2 no 0
Do you eat at least 3 meals per day?	yes 0 no 3
Do you eat fruit or vegetables most days?	yes 0 no 2
Do you eat dairy products most days?	yes 3 no 0
Do you have 3 or more glasses of beer, wine or spirits almost every day?	yes 0 no 1
Do you have 6-8 cups of fluids most days?	yes 4 no 0
Do you have teeth, mouth or swallowing problems that make it hard to eat?	yes 0 no 3
Do you always have enough money to buy food?	yes 2 no 0
Do you eat alone most of the time?	yes 3 no 0
Do you take 3 or more prescribed or over the counter medicines every day?	yes 2 no 0
Without wanting to, have you lost or gained 5kg in the last 6 months?	yes 0 no 2
Are you always able to shop, cook and/or feed yourself?	

Total score

0-3 'good', 4-5 'moderate', 6-29 'high risk'

Comments

MENTAL STATUS

18 Any problems with memory, thinking, planning, motivation?

Consider Folstein, MMSE, AMT

Y
 N

19 Are you living

Alone

Comments

As a couple
With others

20 Social support

a During the last 4 weeks... was someone available to help you if you needed and wanted help? For example if you:

Felt very nervous, lonely or blue
Got sick and had to stay in bed
Needed someone to talk to
Needed help with daily chores
Needed help just taking care of yourself

Yes as much as I wanted
Yes, quite a bit
Yes, some
Yes, a little
No, not at all

Y
 N

b Does this person have a carer?

Y
 N

c Are you responsible for the care of someone else? If yes who/relationship

Y
 N

d Consider Dukes Scale

Y
 D
 N
 O

e Referral to Allied health required?

MOOD / SLEEP

21 Mood (affect)

a During the last 4 weeks... How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted or blue?

Not at all
Slightly
Moderately
Quite a bit
Extremely

0

b Have you had any difficulty sleeping?

Y
 N
 D

Details:

Consider Geriatric Depression Scale

Y
 N

Comment

190301

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i'practice
Record

CONTINENCE

- 22 Continance**
- Leaking urine? N e v e r
S o m e t i m e s
O f t e n
- Is this related to coughing or sneezing? Y N
- Faecal soiling/change of N e v e r
S o m e t i m e s
O f t e n

Comment

bowel habit

HOME SAFETY / HOME VISIT

*Consider home visit
(See appendix for checklist)*

- 23 Home Safety**
- Can you get down to up from your lounge chair easily and safely? Y e s
N o
- Can you get in and out of bed easily and safely? Y e s
N o
- Can you switch on a light easily from your bed? y e s
N o
- Can you get on an off the toilet easily and safely? y e s
N o
- Are all loose mats and floor coverings securely fixed to the floor? Y e s
N o
- Do you use slip resistant mats or self-adhesive non slip strips in the bath/bathroom/shower recess? Y e s
N o
- Can you carry meals easily and safely from the kitchen to your dining area? Y e s
N o
- Are you able to grip and use utensils efficiently and safely? Y e s
- Are the edges of the steps/stairs easily identifiable? Y e s

Actions Suggested eg fitting of hand rails, removal of hazards, improving access

FUNCTIONAL ACTIVITY

- 24 Mobility**
- Can you get around without a mobility aid indoors? Y
N
- Outdoors? Y
N
- Can you bath/shower easily and safely? Y
N
- Can you bend, kneel and stoop easily and safely? Y
- Can you walk 100 metres easily? Y
N
- Can you go up and down access steps to your home or internal stairs easily and safely? Y
N
- Can you easily keep your balance when you reach overhead? Y
N E
- Are your walkways inside and outside the house free of cords and clutter? N E
- Is all the household lighting adequate for you to see clearly? Y N
0
- Have you been free of falls in the home in the past 3 months? Y N
E

Actions suggested

MEDICATION REVIEW

- 25 Complete** the separate Medication Review Sheet
Comment
-

RELEVANT PREVENTIVE CARE CHECKLIST

- 26 Vaccinations** date
- | | | |
|--------------|--|--------------------------|
| Influenza | | <input type="checkbox"/> |
| Pneumococcus | | <input type="checkbox"/> |
| Tetanus | | <input type="checkbox"/> |
| Other | | <input type="checkbox"/> |

Comments

- 27 Other areas for examination and or follow up**
eg Pap smears, weight bearing exercise
-

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PATIENT NAME _____

DOB _____

Carer _____

HISTORY

Is this the only health assessment the patient has undertaken in the last 12 months

Y If so, by
N whom _____

Is patient eligible under Veterans' Affairs

Y If yes, please ensure this form is available on request from
N DVA

GOALS PATIENT / CARERS

CURRENT MEDICAL SITUATION (complete Medication Review sheet separately)

Principal diagnoses

Planned investigation, care, medication (including over the counter complementary and prescriptions from other doctors)

Other significant health problems

OTHER RECOMMENDATIONS

I believe that the patient would benefit from

Care Plan

Y
N

Case Conference

Y
N

Other service to be recommended _____

PATIENT'S AGREEMENT

I have agreed / my carer has agreed to this Health Assessment and understand the recommendations above. Signed by Patient / Carer

date

Signed by GP _____

date

A review date has been set for _____
(MBS rebate available for repeat health assessment after 12 months)

____ / ____ / ____