

## **CTMSP**

CLASSIFICATION BY TYPES OF PROGRAM IN EXTENDED CARE AND SERVICE FACILITIES

## MEDICAL ASSESSMENT FORM

WHAT-GOID!

M.b.: If the space provided for an answer is insufficient, the physician is requested to use a separate sheet to be attached to the form. This applies to all sections of the form

Section 1 Identification

of the physician who performs the medical assessment are also recorded in this section. This information is important should the members of the multidisciplinary team require further details.

Section 2 "Current Situation"

The physician specifies the biological, psychological and social factors that have given rise to the service request submitted by the peneficiary (or other person acting on his behalf) and which have initiated the sufonomy assessment process.

Setion 3 "filiness or Hoalth Problems"

The physician provides his opinion as to the beneficiary's biological, psychological and social condition. This information is vital for the multidisciplinMEDICAL VSSESSMENT FORM equited

Section 4 "Additional Data"

CLASSIFICATION BY TYPES OF PROGRAM IN EXTENDED CARE AND SERVICE FACILITIES

this section is lot iniormation concerning the certain. Place of incomplete the may have, and certain habits use of too constitution of the may have, and certain habits are all aspects of everyday life that provide an indication of the physician should pay particular attention to problems associated with these habits.

IDENTIFICAT				16
Beneficiary's r	name at birth	Health insura	ance no.	Date of birth   year month day   Sex
pouse's name	9			
hysician's na	me		Telephone	License no.   Assessment date
nysiolan s na				
CURRENT S	ITUATION		Section 1	
pecify the bi	ological, psychological and s	ocial factors that have given rise to this s	ervice request.	
	R HEALTH PROBLEMS			
		ems, beginning with the most serious. In for each (for instance, hospitalization, su	raen, physiother	any ergotherapy etc.) and after-effects.
			Tycry, priyalouron	After-effects
/ear	Illness or problem	Intervention		After-effects
ADDITIONA	L DATA			
Approximato	weight:	pprovimate height: All	ergies:	
THE RESERVE LABOUR.		pproximate neight		아마트 하늘이 살아보다 하다 그 나는 아이를 내려왔다면 하다 아니라는 그렇게 다 아그램을 다 먹다.
				duration:
desc	An interest as a transport of			weeping wound:  yes
Habits	No Yes	Give details of any problem (pl	hysical, mental, soc	ial) related to this habit
obacco use	Disease of the Paris	Journal Official August 17 To 19 Special August	cjar eline;	ser octal metalograph frograph
Consumption of	f alcohol			
Orug abuse prescribed or r	not)			
Poor nutrition				

- IDEN	TIFICATION										
Benefic	ciary's name at	birth				Health insura	nce no.	D	ate of birth	month day	Sex
Spouse	's name										
Physici	an's name						Telephone	9	License no.	Assess	ment date
Tilysici	an 3 name										
OUD	TENT CITUATIO	201									<u> </u>
Specif	y the biological	, psy	cholo	gical and social fa	actors that have given	rise to this se	ervice requ	est.			
	9										
		.,									
				14 - 8 \		10 May 10					A 2
3- ILLN	ESS OR HEAL	тн Р	ROB	LEMS			11.1				
List a	ny MAJOR illne	sses	or h	ealth problems, be	eginning with the mos	t serious.					
Speci	fy the type of in	iterve	ntion	undertaken for e	ach (for instance, hosp	italization, sur	gery, physi	otherapy, e	rgotherapy, etc.)	and after	-effects.
Year	Ilin	ess o	r prol	blem	Inter	vention			After-effe	cts	
							in a				
4- ADD	ITIONAL DATA			100							
Annu	wimata waight.	-		Approvi	mate height:	Alle	raies:				1 x 3 2
-					illiate rieigrit						
wound											
		O CHAIL	o ell re	pasid to each o	Give details of a					broblem	
Tobaco	Habits	No	Yes	e program which	n can has, mad his	needs. The n	hasician i	s remeste	dan describe M	ne baneti	ciacy's
	nption of alcohol	# 3·	antu	mary of informa	tion relevant to an a	ssessment o	Tihe serv	icas (be be	Spanciary regu	res and	TO MR
Drug a	buse	nusi	yau)	Aesesment o	I Functional Autor	omy,					
(prescr	bed or not)										
Poor no	utrition				The state of the s						

## 5- SUMMARY ASSESSMENT OF FUNCTIONAL AUTONOMY This section is of vital importance.

This section is of vital importance. It provides information that is crucial in directing the beneficiary toward the most appropriate program (at home or other) in view of his needs. Give details in regard to each of the following aspects, stating the relation with the illnesses and health problems (etiology, interventions, prognosis) identified
PHYSICAL MOBILITY (Transfer, getting about, stairs, endurance, aids, falls, etc.) and DAILY ACTIVITIES (washing, dressing, feeding oneself, etc.)
URINARY INCONTINENCE (Frequency, recurring or permanent, type: paradoxical, effort, reflex)
FEOAL INCONTINUENCE (For an accompany)
FECAL INCONTINENCE (Frequency, recurring or permanent.)
ABILITY TO COMMUNICATE (Specify the diagnosis associated with the handicap)
Eyesight:
Hearing:
rieding.
Speech:
MENTAL FUNCTIONS
Cognitive (orientation, memory, judgment, concentration, comprehension)
Affective (temperament, emotions, will, etc.)
Affective (temperament, emotions, will, etc.)
D) His 2018 and any dark task (asilines
a) described addition is seen distance familiary of materials provide measurements.
INS DUASCUSE QUONICISA TE STACOS DE COUCAIDEDA
BEHAVIOUR (agressiveness, violence, tendency to give way to fugue, exhibitionism, etc.)

## 5- SUMMARY ASSESSMENT OF FUNCTIONAL AUTONOMY

This section is of vital importance. It provides information that is crucial in directing the beneficiary toward the most appropriate program (at home or other) in view of his needs. Give details in regard to each of the following aspects, stating the relation with the illnesses and health problems (etiology, interventions, prognosis) identified
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URINARY INCONTINENCE (Frequency, recurring or permanent, type: paradoxical, effort, reflex)
FECAL INCONTINENCE (Frequency, recurring or permanent.)
ABILITY TO COMMUNICATE (Specify the diagnosis associated with the handicap)
Eyesight: Hearing:
Hearing: Speech:
MENTAL FUNCTIONS
Cognitive (orientation, memory, judgment, concentration, comprehension)
C) the care and services he needs because of his condition and the associated restrictions. The "other" cate-  We describe the care and services he needs because of his condition and the associated restrictions. The "other" cate-  The care and services he needs because of his condition and the associated restrictions. The "other" cate-  The care and services he needs because of his condition and the associated restrictions. The "other" cate-  The care and services he needs because of his condition and the associated restrictions. The "other" cate-  The care and services he needs because of his condition and the associated restrictions. The "other" cate-  The care and services he needs because of his condition and the associated restrictions. The "other" cate-  The care and services he needs because of his condition and the associated restrictions.
b) his dief and any barticular features
a) the pengliciary's medication mame of medicine, dose, posology).
BEHAVIOUR (agressiveness, violence, tendency to give way to fugue, exhibitionism, etc.)
producer a positive result. When he feels it is immurfant, the obvisional may affach the examination reporting is
ned, lockutlag results which indicate there is no problem. A complete moture of the bendictary's candition depends just as much on knowing the examinations which talked to flater, any problem as on being eware of those which
The chysician is requested to report the results of any chaminations which would influentiful mambers of the multi- clisciplinary feam assessing the services required of the type of rowstigation already made and the results obtain
Section 6 "Relevant Seports from Camplementary Examinations and Consultations"

## Proposed Interventions  ## MEDICATION For each prescription medicine, provide  Name - dose - positiogy - how administered - anticipated duration  ### Has the beneficiary been observed to have difficulty administering his medication?   yes   no    ### If yes, specify:  ### FOOD AND DIET				
MEDICATION For each prescription medicine, provide  Vane - dose - posology - how administered - anticipated duration  Has the beneficiary been observed to have difficulty administering his medication?   yes   no    If yes, specify:  COOD AND DIET				
MEDICATION For each prescription medicine, provide  Vane - dose - posology - how administered - anticipated duration  Has the beneficiary been observed to have difficulty administering his medication?   yes   no    If yes, specify:  COOD AND DIET				
MEDICATION For each prescription medicine, provide  Vane - dose - posology - how administered - anticipated duration  Has the beneficiary been observed to have difficulty administering his medication?   yes   no    If yes, specify:  COOD AND DIET				
MEDICATION For each prescription medicine, provide    Aame - dose - posology - how administered - anticipated duration				
MEDICATION For each prescription medicine, provide  lame - dose - posology - how administered - anticipated duration  Has the beneficiary been observed to have difficulty administering his medication?   If yes, specify:  COD AND DIET    balanced				
MEDICATION For each prescription medicine, provide lame - dose - posology - how administered - anticipated duration  Has the beneficiary been observed to have difficulty administering his medication?     Has the beneficiary been observed to have difficulty administering his medication?    Jesus				
MEDICATION For each prescription medicine, provide lame - dose - posology - how administered - anticipated duration  Has the beneficiary been observed to have difficulty administering his medication?   yes   no   ff yes, specify:  COD AND DIET   high fibre content   low sugar   no salt   other, specify    CARE/SERVICES   No   Yes   ff yes, apecify the care/service needs and restrictions    - physiotherapy   ergotherapy   especific nursing care   specific nursing care   social service   ended   other(s)    - other(s)   OTHER (further assessment, etc.)				
MEDICATION For each prescription medicine, provide lame - dose - posology - how administered - anticipated duration  Has the beneficiary been observed to have difficulty administering his medication?   yes   no   ff yes, specify:  COD AND DIET   high fibre content   low sugar   no salt   other, specify    CARE/SERVICES   No   Yes   ff yes, apecify the care/service needs and restrictions    - physiotherapy   ergotherapy   especific nursing care   specific nursing care   social service   ended   other(s)    - other(s)   OTHER (further assessment, etc.)				
AEDICATION For each prescription medicine, provide same - dose - posology - how administered - anticipated duration  Has the beneficiary been observed to have difficulty administering his medication?     description				
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Ass the beneficiary been observed to have difficulty administering his medication?   yes   no   f yes, specify:  OOD AND DIET   balanced   high fibre content   low sugar   no salt   other, specify    Physiotherapy   ergotherapy   ergotherapy   ergotherapy   ergotherapy   ergotherapy   especific nursing care   especific				
ame - dose - posology - how administered - anticipated duration    description   descr	MEDICATION For each prescr		No. 1	
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If yes, specify:  OOD AND DIET    balanced				
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f yes, specify:  OOD AND DIET    balanced				
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CARE/SERVICES	Has the beneficiary been obse	erved t	o have	ifficulty administering his medication? Layes Land
CARE/SERVICES	If yes, specify:			
balanced   high fibre content   low sugar   no salt     other, specify				
balanced high fibre content low sugar no salt other, specify  CARE/SERVICES  No Yes If yes, specify the care/service needs and restrictions  physiotherapy ergotherapy respiration therapy oxygen therapy specific nursing care social service other(s)  OTHER (further assessment, etc.)	1 3 3 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1			
Other, specify  CARE/SERVICES  No Yes If yes, specify the care/service needs and restrictions  physiotherapy ergotherapy respiration therapy oxygen therapy specific nursing care social service other(s)  OTHER (further assessment, etc.)				
Other, specify  CARE/SERVICES  No Yes If yes, specify the care/service needs and restrictions  • physiotherapy  • ergotherapy  • respiration therapy  • speech therapy  • specific nursing care  • social service  • other(s)  OTHER (further assessment, etc.)	balanced	high	fibre co	ntent low sugar no salt
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respiration therapy     oxygen therapy     speech therapy     specific nursing care     social service     other(s)  OTHER (further assessment, etc.)				tradition to a familiar and representation of the statement of the stateme
oxygen therapy     speech therapy     specific nursing care     social service     other(s)  OTHER (further assessment, etc.)				
speech therapy     specific nursing care     social service     other(s)  OTHER (further assessment, etc.)				the state of the s
specific nursing care     social service     other(s)  OTHER (further assessment, etc.)				
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ALIILIDA III.	social service     other(s)	etc.)	12.231	De julio a minimisco le migratiana pra Propraminia modantita Angari se escapita pa es

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	PLEMENTARY EXAMINATIONS AND CONSULTATIONS  eurology, psychiatry, etc. Attach report, if deemed advisable.)	
(Laboratory, X-ray, priysiotrierap)	urology, psychiatry, etc. Attach report, in deemed advisable.)	
4-4		
PROPOSED INTERVENTIONS		
A. MEDICATION For each preso	on medicine, provide	
Name - dose - posology - how add	ered - anticipated duration	13
Gurde AS-628A		
be witnessed		
This is to be a	ed by the beneficiary or if he is anable to do so, by an authorized berson. The form must a	HSO-
Has the beneficiary been obs	ed to have difficulty administering his medication?  yes no	
If yes, specify:		
n yee, speeny.	2.000	
signs it and e	s the date the form was completed.	
B. FOOD AND DIET	nd to the future program direction of the beneficiary. Once he has completed the form, the physic	
balanced the bulkarcies	igh fibre content la low sugar and no salt housely to the lumping schemes A teelus a assessment	
	ther, specify	
	nation Deemed Important or Specific Recommendation(s) by the Physician"	
	and the state of t	
C. CARE/SERVICES		
Hoali or Hoal	No Yes If yes, specify the care/service needs and restrictions	
• physiotherapy	physician is requested not to make any commitments to the deneficiary with respect to a pla	ICS-
• ergotherapy		
• respiration therapy	ate proprain for the beneficiary. As a result, and so that the heneficiary will not form any spec-	
<ul> <li>oxygen therapy</li> </ul>	ould regize that his assessment is part of an everall assessment procedure dealoned to se	10.01
<ul> <li>speech therapy</li> </ul>		
specific nursing care	ect ester to provide his eminion as to the most appropriate services to meet the beneficiary's nee	145
• social service		
• other(s)	Opmion as to Most Appropriate Services for the Seneticiary	
D. OTHER (further assessment,		
	ted to change. This information is indispensible for the multidisciplinary team assessing the	
The physician	equiested to give his appaian on how the beneficiery a planginal insychological and social co	adı.
Comments: 3		
Commonto.		

/ higherical condition		
1 Diological conditi	tion is stable unstable	
e beneficiary's psychological conditi	tion is stable unstable	
social condit	tion is stable unstable	
/hat is your prognosis as to how his biolog	gical, psychological and social condition can be expected to chan	ge?
PHYSICIAN'S OPINION AS TO THE MOS	ST APPROPRIATE SERVICES FOR THE BENEFICIARY	egraph control of the sight of
	on (health, living conditions, etc.), what type of services do you fee	are best suited to his needs?
continuation (return to) the home (	(day centre, day hospital, home care/services, temporary accomod	ation)
institutional resources (ECHC, HCC		
Give details as to the type of services		
re you the beneficiary's physician? □y	yes □no How long have you kno mation when you performed your assessment? □yes □no	wn him?
lid you have the necessary medical inform		
Did you have the necessary medical inform	Physician's signature	Date
_	Physician's signature	Date
_	Physician's signature	Date
_	• to releas	Date se the information contained in
- BENEFICIARY'S AUTHORIZATION  I authorize		
I- BENEFICIARY'S AUTHORIZATION  I authorize this form to the persons responsible for	name of physician for evaluating my application for services.	se the information contained in
I- BENEFICIARY'S AUTHORIZATION  I authorize	name of physician for evaluating my application for services.	
I- BENEFICIARY'S AUTHORIZATION  I authorize this form to the persons responsible for	name of physician for evaluating my application for services.	se the information contained in
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- BENEFICIARY'S AUTHORIZATION  I authorize this form to the persons responsible for	name of physician for evaluating my application for services.	se the information contained i

8- PROGNOSIS
The beneficiary's biological condition is stable unstable psychological condition is stable unstable social condition is stable unstable unstable
What is your prognosis as to how his biological, psychological and social condition can be expected to change?
9- PHYSICIAN'S OPINION AS TO THE MOST APPROPRIATE SERVICES FOR THE BENEFICIARY
In view of the beneficiary's current situation (health, living conditions, etc.), what type of services do you feel are best suited to his needs?
continuation (return to) the home (day centre, day hospital, home care/services, temporary accomodation)  intermediate resources (foster family, pavilion)  institutional resources (ECHC, HCC, STCHC)  Give details as to the type of services and under what condition(s):
10- OTHER INFORMATION DEEMED IMPORTANT OR SPECIFIC RECOMMENDATIONS BY THE PHYSICIAN
Are you the beneficiary's physician?
Did you have the necessary medical information when you performed your assessment?
Physician's signaturel Date
11- BENEFICIARY'S AUTHORIZATION
I authorize to release the information contained in
I authorize to release the information contained in   this form to the persons responsible for evaluating my application for services.
(IN CASE OF INCAPACITY)
Witness
Date of authorization