Santé et Services sociaux Québec

DT9144

Date of birth (Year / Month / Day)	Room no.	File no.

First and last name at birth

Usual name or spouse's name

Address

Postal code	Telephone no. (Area code)	Sex
		M ☐ F ☐

Health insurance no.	Name of attending physician

Date of assessment	Assessment no.

MULTICLIENTELE

AUTONOMY ASSESSMENT

File no.

Specify, if necessary, the source of information: **U**ser – **F**amily or **F**riend – **E**valuator | **Problem**

STATE OF HEALTH

1. PERSONAL AND FAMILY HEALTH HISTORY AND CURRENT DIAGNOSES (physical and mental illness, – including chronic or stabilized problems –, congenital defects, hospitalizations, surgeries, traumas)

Allergies (medication, food, environment) : _____

2. PHYSICAL HEALTH

Difficulties experienced or specific observations	No	Yes
• **Digestive** function (pain, nausea, vomiting, diarrhea, constipation, gas, dysphagia, etc.) If so, specify: _____	☐	☐
• **Respiratory** function (pain, coughing, sputum, breathing difficulties, etc.) If so, specify: _____	☐	☐
• **Cardiovascular** function (pain, palpitations, pacemaker, etc.) If so, specify: _____	☐	☐
• **Genitourinary** function (pain, urinary problems, genital or gynecological problems, etc.) If so, specify: _____	☐	☐
• **Motor** function (pain, deformation, limited movement, strength, coordination, trembling, balance, physical endurance, etc.) If so, specify: _____	☐	☐
• **Sensory** function: eyes, ears, nose, mouth, touch (pain, discharge, inflammation, sensitivity, etc.) If so, specify: _____	☐	☐
• **Skin** function (wounds, redness, swelling, discharge, etc.) If so, specify: _____	☐	☐
• Other information If so, specify: _____	☐	☐

Height: _____ Weight: _____ Weight gain or loss: _____ If relevant: _____ B.P. _____ Pulse _____ Resp. _____ T°

Comments: _____

Problem identified

No — **N**

Yes — **Y**

File no.

AUTONOMY ASSESSMENT

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

3. PSYCHOLOGICAL HEALTH (depressed, suicidal, paranoid, delirious, violent, manic, etc.)

Difficulties experienced or specific observations: ☐ No

☐ If so, specify: _____

_____

_____

Comments: _____

_____

_____

Problem identified — **No** N / **Yes** Y

4. SPECIFIC CARE (care required by user: bandages, various catheter care, oxygen, aspiration of secretions, postural drainage, peritoneal dialysis, etc., and other care as requested)

☐ No

☐ Yes, description, frequency and by whom: _____

_____

_____

Comments: _____

_____

_____

Problem identified — **No** N / **Yes** Y

5. MEDICATION (prescribed or not prescribed)

Name of pharmacy: _____

Area code | Telephone no. | Area code | Fax no. | E-mail

Name of medication	Dosage and frequency	User's explanation of reason	Prescribing physician	Prescribed	
				Yes	No

Side effects: ☐ No ☐ Yes Medication compliance: ☐ No ☐ Yes

Comments: _____

_____

_____

Problem identified — **No** N / **Yes** Y

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

6. HEALTH SERVICES (medical, rehabilitation, alternative medicine, psychology, podiatry, etc.)

Regular medical checkup: ☐ No ☐ Yes

Family doctor: _____

Area code | Telephone no. | Extension | Area code | Fax no. | E-mail

Specialist: _____

Area code | Telephone no. | Extension | Area code | Fax no. | E-mail

Specialist: _____

Area code | Telephone no. | Extension | Area code | Fax no. | E-mail

Other: _____

Area code | Telephone no. | Extension | Area code | Fax no. | E-mail

Comments (specify required services not yet received): _____

Problem identified — **No** — **N** / **Yes** — **Y**

LIVING HABITS

1. NUTRITION

Daily diet:

Milk and dairy products: ☐ Yes ☐ No

Meat and meat substitutes: ☐ Yes ☐ No

Fruits and vegetables: ☐ Yes ☐ No

Bread and cereals: ☐ Yes ☐ No

Liquid intake: _____ cups or glasses

Diet: ☐ No ☐ Yes, specify: _____

Prescribed: ☐ Yes ☐ No

Followed: ☐ Yes ☐ No

Alimentation for dysphagia: ☐ Yes ☐ No

Other observations (time and location of meals, eats with whom, appetite, etc.):

Difficulties experienced or specific observations: ☐ No

☐ Yes, specify: _____

Are the user's current eating habits satisfactory to him/her? ☐ Yes ☐ No

Dentition (pain, difficulty chewing, denture, etc.):

Difficulties experienced or specific observations: ☐ No

☐ Yes, specify: _____

Comments: _____

Problem identified — **No** — **N** / **Yes** — **Y**

File no.

AUTONOMY ASSESSMENT

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

2. SLEEP (insomnia, wakes up and why, fear, agitation, medication, time of rising and retiring, nap, etc.)

Difficulties experienced or specific observations: ☐ No

☐ Yes, specify: _____

Are the user's current sleeping habits satisfactory to him/her? ☐ Yes ☐ No

Comments: _____

Problem identified — No — N / Yes — Y

3. TOBACCO USE (type of consumption, quantity, supervision required, motivation to stop smoking, etc.)

Smokes: ☐ No

☐ Yes, specify: _____

Does the user's smoking currently pose a problem to him/her? ☐ Yes ☐ No

Comments: _____

Problem identified — No — N / Yes — Y

4. ALCOHOL AND DRUG USE (odor of alcohol, outward signs, type of consumption, quantity, frequency, supervision required, motivation to change habit, etc.)

Uses alcohol or drugs: ☐ No

☐ Yes, specify: _____

Does this habit currently pose a problem to the user? ☐ Yes ☐ No

Comments: _____

Problem identified — No — N / Yes — Y

5. PERSONAL AND LEISURE ACTIVITIES (participation in work, study or leisure activities, usual activities, desired activities, obstacles, etc.)

Difficulties experienced or specific observations: ☐ No

☐ Yes, specify: _____

Are the user's current personal and leisure activities satisfactory to him/her? ☐ Yes ☐ No

Comments: _____

Problem identified — No — N / Yes — Y

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

A. ACTIVITIES OF DAILY LIVING (ADL)

1. EATING

0 Feeds self independently

-0,5 With difficulty

-1 Feeds self but needs stimulation or supervision
OR food must be prepared or cut or pureed first

-2 Needs some assistance to eat
OR dishes must be presented one after another

-3 Must be fed totally by another person
OR has a naso-gastric tube or a gastrostomy

☐ naso-gastric tube ☐ gastrostomy

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ___ ___ ___

− + •

Comments (e.g., technical aids used): _____

2. WASHING

0 Washes self independently (including getting in or out of the bathtub or shower)

-0,5 With difficulty

-1 Washes self but needs stimulation
OR needs supervision
OR needs preparation
OR needs help for the complete weekly bath only
(including washing feet and hair)

-2 Needs help for the daily wash but participates actively

-3 Must be washed by another person

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ___ ___ ___

− + •

Comments (habits and frequency: bath, shower, washing hair, equipment used, help getting in and out, etc.):

3. DRESSING (all seasons)

0 Dresses self independently

-0,5 With difficulty

-1 Dresses self but needs stimulation
OR needs supervision
OR clothing must be prepared and presented
OR needs help for finishing touches
(buttons, laces, support hose/stocking)

-2 Needs help dressing

-3 Must be dressed by another person

☐ support hose/stocking

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ___ ___ ___

− + •

Comments (usual clothing, technical aids used): _____

*** Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

4. GROOMING (brushes teeth or combs hair or shaves or trims finger or toenails or puts on makeup)

0 Grooms self independently

-0,5 With difficulty

-1 Needs stimulation
OR needs supervision for grooming

-2 Needs some assistance for grooming

-3 Must be groomed by another person

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

0 [−] [+] [•] -1 -2 -3

Comments (e.g., technical aids used): _____

5. URINARY FUNCTION

0 Normal voiding

-1 Occasional incontinence
OR dribbling
OR needs frequent stimulation to avoid incontinence

-2 Frequent urinary incontinence

-3 Complete and habitual urinary incontinence
OR wears an incontinence pad or an indwelling catheter
or a urinary condom

☐ incontinence pad ○ night incontinence

☐ urinary condom ○ day incontinence

☐ indwelling catheter

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

0 [−] [+] [•] -1 -2 -3

Comments: _____

6. BOWEL FUNCTION

0 Normal bowel function

-1 Occasional incontinence
OR needs cleansing enema occasionally

-2 Frequent incontinence
OR needs cleansing enema regularly

-3 Always incontinent
OR wears an incontinence pad or an ostomy

☐ incontinence pad ○ night incontinence

☐ ostomy ○ day incontinence

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

0 [−] [+] [•] -1 -2 -3

Comments: _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

7. TOILETING

0 Uses toilet independently
(including getting on/off toilet, wiping self and managing clothing)

-0,5 With difficulty

-1 Needs supervision for toileting
OR uses commode, urinal or bedpan

-2 Needs help to go to the toilet
OR uses commode, bedpan or urinal

-3 Does not use toilet, commode, bedpan or urinal

☐ commode ☐ bedpan ☐ urinal

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments (frequency, equipment used, number of people to help, etc.): _____

B. MOBILITY

1. TRANSFERS (bed to chair or wheelchair to standing and vice-versa)

0 Gets in and out of bed or chair independently

-0,5 With difficulty

-1 Gets in and out of bed/chair independently but needs stimulation, supervision or guidance
specify: _____

-2 Needs help to get in or out of bed/chair
specify: _____

-3 Bedridden (must be lifted in and out of bed)
☐ particular positioning
☐ lift ☐ transfer board

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments (number of people to help, mobility in bed, precision of positioning, etc.): _____

2. WALKING INSIDE (including in the building and going to the elevator) [1]

0 Walks independently (with or without cane, prosthesis, orthosis or walker)

-0,5 With difficulty

-1 Walks independently but needs guidance, stimulation or supervision in certain circumstances
OR unsafe gait

-2 Needs help of another person to walk

-3 Does not walk

☐ cane ☐ tripod cane ☐ quadripod cane ☐ walker

[1] Distance of at least 10 metres

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments (e.g., walking area): _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

3. INSTALLING PROSTHESIS OR ORTHOSIS

0 Does not wear prosthesis or orthosis

-1 Installs prosthesis or orthosis independently

-1,5 With difficulty

-2 Installing of prosthesis or orthosis needs checking OR needs some assistance

-3 Prosthesis or orthosis must be install by another person

Type of prosthesis or orthosis: _____

_____

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

_____

_____

4. PROPELLING A WHEELCHAIR (W/C) INSIDE

0 Does not need a wheelchair

-1 Propels wheelchair independently

-1,5 With difficulty

-2 Needs to have wheelchair pushed

-3 Unable to use wheelchair (must be transported on stretcher)

- ☐ standard wheelchair
- ☐ wheelchair with unilateral axis
- ☐ motorized wheelchair
- ☐ three-wheeled scooter
- ☐ four-wheeled scooter

• Does the user's residence allow for W/C or scooter mobility?

☐ Yes → 0

☐ No

• Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

_____

_____

5. NEGOTIATING STAIRS

0 Goes up and down stairs independently

-0,5 With difficulty

-1 Requires stimulation, supervision or guidance to negotiate stairs OR does not safely negotiate stairs

-2 Needs help of another person to go up and down stairs

-3 Does not negotiate stairs

Does the user have to negotiate stairs?

☐ No → 0

☐ Yes

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

_____

_____

*** Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: − lessen, + increase, • remain stable, or does not apply.

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

6. GETTING AROUND OUTSIDE

0 Walks independently (with or without cane, prosthesis, orthosis or walker) [2]

-0,5 With difficulty

-1 Uses a wheelchair or three/four-wheeled scooter independently **

-1,5 W/C with difficulty

OR walks independently but needs guidance, stimulation or supervision in certain circumstances
OR unsafe gait [2]

-2 Needs help of another person to walk [2]
OR to use W/C **

-3 Cannot move around outside (must be transported on a stretcher)

[2] Distance of at least 20 metres

** Does the outside environment of the user's residence allow for W/C or scooter access and mobility?

☐ Yes → 0

☐ No

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

− + •

Comments (e.g., walking area): _____

C. COMMUNICATION

1. VISION

0 Sees adequately with or without corrective lenses

-1 Vision problems but sees enough for ADLs

-2 Only sees outlines of objects and needs guidance in ADLs

-3 Blind

☐ corrective lenses ☐ magnifying glass

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments (e.g., which eye): _____

2. HEARING

0 Hears adequately with or without hearing aid

-1 Hears if spoken to in a loud voice
OR needs hearing aid put in by another person

-2 Only hears shouting or certain words
OR reads lips
OR understands gestures

-3 Completely deaf and unable to understand what is said to him/her

☐ hearing aid

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments (which ear, hearing aid installed on telephone, other technical aids, etc.): _____

*** Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

DISABILITIES | **HANDICAP**

Specify, if necessary, the cause and the user's reaction to this disability.

3. SPEAKING

0 Speaks normally

-1 Has a speech/language problem but able to express him/herself

-2 Has a major speech/language problem but able to express basic needs
OR answer simple questions (yes, no)
OR uses sign language

-3 Does not communicate

Technical aid: ☐ computer ☐ communication board

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0 − + •

☐ No → -1 -2 -3

Resources*: ☐☐☐

Comments (e.g., type of compensation): _____

Written expression and understanding: _____

D. MENTAL FUNCTIONS

For each element, specify when the disability started and the user's reaction to this disability.

1. MEMORY

0 Normal memory

-1 Minor recent memory deficit (names, appointments, etc.) but remembers important facts

-2 Serious memory lapses (shutting off stove, taking medications, putting things away, eating, visitors, etc.)

-3 Almost total memory loss or amnesia

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0 − + •

☐ No → -1 -2 -3

Resources*: ☐☐☐

Comments: _____

2. ORIENTATION

0 Well oriented to time, place and persons

-1 Sometimes disoriented to time, place and persons

-2 Only oriented for immediate events (i.e., time of day) and in the usual living environment and with familiar persons

-3 Complete disorientation

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0 − + •

☐ No → -1 -2 -3

Resources*: ☐☐☐

Comments: _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

3. COMPREHENSION

0 Understands instructions and requests

-1 Slow to understand instructions and requests

-2 Partial understanding even after repeated instructions OR is incapable of learning

-3 Does not understand what goes on around him/her

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments: _____

4. JUDGMENT

0 Evaluates situations and makes sound decisions

-1 Evaluates situations but needs help in making sound decisions

-2 Poorly evaluates situations and only makes sound decisions with strong suggestions

-3 Does not evaluate situations and is dependent on others for decision making

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments: _____

5. BEHAVIOR

0 Appropriate behavior

-1 Minor behavioral problems (whimpering, emotional lability, stubbornness, apathy) requiring occasional supervision or a reminder or stimulation

-2 Major behavioral problems requiring more intensive supervision (aggressive towards self or others, disturbs others, wanders, yells out constantly)

-3 Dangerous, requires restraint OR harmful to others or self-destructive OR tries to run away

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments: _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

E. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (household tasks)

1. HOUSEKEEPING

0 Does housekeeping alone (including daily housework and occasional heavy jobs)

-0,5 With difficulty

-1 Does housekeeping (including washing the dishes) but needs stimulation or supervision to ensure cleanliness OR needs help for occasional heavy jobs (floors, windows, painting, lawn, shoveling snow, etc.)

-2 Needs help for daily housework

-3 Does not do housework

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

Stability ■: 0 [−] [+] [•]

Comments: _____

2. MEAL PREPARATION

0 Prepares own meals independently

-0,5 With difficulty

-1 Prepares meals but needs stimulation to maintain adequate nutrition

-2 Only prepares light meals OR reheats pre-prepared meals (including handling the plates)

-3 Does not prepare meals

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

Stability ■: 0 [−] [+] [•]

Comments: _____

3. SHOPPING

0 Plans and does shopping independently (food, clothes, etc.)

-0,5 With difficulty

-1 Plans and shops independently but needs to be delivered service

-2 Needs help to plan or to shop

-3 Does not shop

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐ ☐ ☐

Stability ■: 0 [−] [+] [•]

Comments (specify the activities the user cannot perform): _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

4. LAUNDRY

0 Does all laundry independently

-0,5 With difficulty

-1 Does laundry but needs stimulation or supervision to maintain standards of cleanliness

-2 Needs help to do laundry

-3 Does not do laundry

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

5. TELEPHONE

0 Uses telephone independently (including the use of a directory)

-0,5 With difficulty

-1 Answers telephone but only dials a few memorized numbers or emergency numbers

-2 Communicates by telephone but does not dial numbers or lift the receiver off the hook

-3 Does not use the telephone

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments (e.g., special equipment): _____

6. TRANSPORTATION

0 Able to use transportation alone (car, adapted vehicle, taxi, bus, etc.)

-0,5 With difficulty

-1 Must be accompanied to use transportation OR uses paratransit independently

-2 Uses car or paratransit only if accompanied and has help getting in and out of the vehicle

-3 Must be transported on a stretcher

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

0 − + •

Comments: _____

*** Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

STABILITY OF RESOURCES ■

DISABILITIES	HANDICAP

Specify, if necessary, the cause and the user's reaction to this disability.

7. MEDICATION USE

0 Takes medication unaided according to prescription
OR does not need medication

-0,5 With difficulty

-1 Needs supervision (including supervision from afar)
to ensure compliance to prescription
OR uses a medication dispenser aid (prepared by someone else)

-2 Takes medication if prepared daily

-3 Must be given each dosage of medication (as prescribed)

☐ medication dispenser aid

Does the user presently have the human resources (help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments: _____

8. BUDGETING

0 Manages budget independently (including banking)

-0,5 With difficulty

-1 Needs help for certain major transactions

-2 Needs help for some regular transactions
(cashing checks, paying bills) but uses pocket money wisely

-3 Does not manage budget

Does the user presently have the human resources ((help or supervision) necessary to overcome this disability?

☐ Yes → 0

☐ No → -1 / -2 / -3

Resources*: ☐☐☐

Stability: 0 [−] [+] [•]

Comments (e.g., banking procuration): _____

* **Resources: 0.** User himself, **1.** Family, **2.** Neighbor, **3.** Employee, **4.** Aides, **5.** Nurse, **6.** Volunteer, **7.** Other, **8.** Attendant.

■ **Stability:** In the next 3 or 4 weeks, is it foreseeable that these resources will: [−] lessen, [+] increase, [•] remain stable, or does not apply.

File no.

Specify, if necessary, the source of information: **U**ser – **F**amily or **F**riend – **E**valuator | **Problem**

PSYCHOSOCIAL SITUATION

1. SOCIAL HISTORY (occupation, married, divorced, mourning, education level, immigration, moves, other major events, etc.)

Comments:

Problem identified — No — N; Yes — Y

2. FAMILY SITUATION

Family makeup (age, sex, place of residence or genogram):

Family dynamics (interaction of user with family and family members with each other, user's satisfaction with family situation, how the family reacts or is affected by the user's situation, signs of abuse, violence or negligence, etc.):

Comments:

Problem identified — No — N; Yes — Y

3. MAIN CAREGIVERS (involvement, level of fatigue, impressions of their situation, expectations, desire to get involved, etc.)

Comments:

Problem identified — No — N; Yes — Y

File no.

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

4. SOCIAL NETWORK (including school and work environment)

Significant persons (friends, neighbors, colleagues, teachers, etc.): _____

Relationship dynamics (interaction of user with members of his/her social network, satisfaction of user with regard to his/her relations with them, how they react to or are affected by the user's situation, signs of abuse, violence or negligence, etc.):

Comments: _____

Problem identified — No — N / Yes — Y

5. COMMUNITY, PUBLIC AND PRIVATE RESOURCES (volunteers, associations, day centers, paratransit, services included in lease, etc.)

Specify the type of services, their frequency, and the user's interaction with them: _____

Comments (services required but not yet received): _____

Problem identified — No — N / Yes — Y

6. AFFECTIVE STATE (mood, self esteem, feelings of usefulness or isolation, anxiety, etc.)

Comments: _____

Problem identified — No — N / Yes — Y

File no.

Specify, if necessary, the source of information: User – Family or Friend – Evaluator | **Problem**

7. USER'S IMPRESSIONS (how user perceives his/her situation, reacts or adapts to it, motivation, solutions envisioned, etc.)

Comments:

Problem identified — No — N; Yes — Y

8. SEXUALITY (satisfaction of user, preoccupation, socially unacceptable behavior, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify:

Comments:

Problem identified — No — N; Yes — Y

9. PERSONAL, CULTURAL AND SPIRITUAL BELIEFS AND VALUES (e.g., expression)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify:

Comments:

Problem identified — No — N; Yes — Y

ECONOMIC CONDITIONS

CAPACITY TO MEET FINANCIAL OBLIGATIONS WITH CURRENT INCOME (rent, food, clothing, medication, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify:

Does the user benefit from one of the following programs: guaranteed income supplement, Quebec pension, housing assistance, disability pension, income security, special family allowance, other: ☐ No ☐ Yes

Yes, specify:

Comments:

Problem identified — No — N; Yes — Y

File no.

Specify, if necessary, the source of information: **U**ser – **F**amily or **F**riend – **E**valuator | **Problem**

PHYSICAL ENVIRONMENT

1. HOUSING CONDITIONS (cleanliness, space, satisfaction, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify: _____

☐ Owner ☐ Tenant ☐ Boarder ☐ Address unknown Lived there since: _____

Residence on: _____ floor Number of rooms: _____

Access: ☐ elevator ☐ interior strairway, number of steps: _____ ☐ exterior stairway, number of steps: _____

Comments: _____

Problem identified — **No** N / **Yes** Y

2. PERSONAL AND ENVIRONMENTAL SAFETY (risk of falling, fire, running away, emergency telephone system, warning lights, telemonitoring, remote monitoring system, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify: _____

Comments (needs not met): _____

Problem identified — **No** N / **Yes** Y

3. ACCESSIBILITY (architectural barriers, location of equipment, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify: _____

Comments (needs not met): _____

Problem identified — **No** N / **Yes** Y

4. PROXIMITY OF SERVICES (grocery store, bank, church, laundromat, etc.)

Difficulties experienced or specific observations: ☐ No ☐ Yes, specify: _____

Comments: _____

Problem identified — **No** N / **Yes** Y

File no.

SUMMARY (context of assessment, urgent problems identified, user's expectations, risk factors, suggested orientations)

Year Month Day

Signature Title Date