Santé et Services sociaux Québec

DT9213

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

MULTICLIENTELE
AUTONOMY ASSESSMENT SHORT-TERM CARE CLIENTELE

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

File no.

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

2. PHYSICAL HEALTH (cont'd)

Difficulties experienced or specific observations — No ☐ Yes ☐

- **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**

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**

File no.

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

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**

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

	Problem	
	No	Yes
1. Nutrition		
2. Sleep		
3. Tobacco use		
4. Alcohol and drug use		
5. Personal and leisure activities		

If user has problems or disabilities, specify:

_____

_____

_____

_____

AUTONOMY ASSESSMENT
SHORT-TERM CARE CLIENTELE

File no.

‡ **Indicate:** Disability level: **0** = Completely autonomous **-0,5 ou -1,5** = Autonomous with some difficulty **-1** = Requires monitoring or stimulation **-2** = Requires help **-3** = Totally dependent

Handicap level: **H** (0, -1, -2, -3) Stability of resources: **S** (**–** Decrease, **+** Increase, • Stable)

ADL‡

Disabilities						H	S
0	-0,5	-1	-1,5	-2	-3		
1. Eating				■			
2. Washing				■			
3. Dressing				■			
4. Grooming				■			
5. Urinary function		■		■			
6. Bowel function		■		■			
7. Toileting				■			

Technical Aid

If user has problems or disabilities, specify:

MOBILITY‡

Disabilities						H	S
0	-0,5	-1	-1,5	-2	-3		
1. Transfers			■				
2. Walking inside			■				
3. Installing prosthesis or orthosis		■					
4. Propelling a wheelchair (W/C) inside		■					
5. Negotiating stairs			■				
6. Getting around outside							

Technical Aid

COMMUNICATION‡

Disabilities						H	S
0	-0,5	-1	-1,5	-2	-3		
1. Vision		■		■			
2. Hearing		■		■			
3. Speaking		■		■			

Technical Aid

MENTAL FUNCTIONS‡

Disabilities						H	S
0	-0,5	-1	-1,5	-2	-3		
1. Memory		■		■			
2. Orientation		■		■			
3. Comprehension		■		■			
4. Judgment		■		■			
5. Behavior		■		■			

Technical Aid

INSTRUMENTAL (ADL)‡

Disabilities						H	S
0	-0,5	-1	-1,5	-2	-3		
1. Housekeeping				■			
2. Meal preparation				■			
3. Shopping				■			
4. Laundry				■			
5. Telephone				■			
6. Transportation				■			
7. Medication use				■			
8. Budgeting				■			

Technical Aid

File no.

AUTONOMY ASSESSMENT
SHORT-TERM CARE CLIENTELE

PSYCHOSOCIAL SITUATION

	Problem	
	No	Yes
1. Social history		
2. Family situation		
3. Main caregivers		
4. Social network		
5. Community, public and private resources		
6. Affective state		
7. User's impressions		
8. Sexuality		
9. Personal, spiritual beliefs and values		

If user has problems or disabilities, specify:

ECONOMIC CONDITIONS

	Problem	
	No	Yes
1. Capacity to meet obligations		

PHYSICAL ENVIRONMENT

	Problem	
	No	Yes
1. Housing conditions		
2. Personal and environmental safety		
3. Accessibility		
4. Proximity of services		

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

Year Month Day

Signature Title Date