Gouvernement du Québec
Ministère de la Santé et des Services sociaux

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

MEDICAL ASSESSMENT FORM

AS-528A

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MEDICAL ASSESSMENT FORM

MÉDECIN

1- IDENTIFICATION

Beneficiary's name at birth	Health insurance no.	Date of birth (year / month / day)	Sex ☐F ☐M

Spouse's name

Physician's name	Telephone	License no.	Assessment date

2- CURRENT SITUATION

Specify the biological, psychological and social factors that have given rise to this service request.

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3- ILLNESS OR HEALTH PROBLEMS

List any MAJOR illnesses or health problems, beginning with the most serious.
Specify the type of intervention undertaken for each *(for instance, hospitalization, surgery, physiotherapy, ergotherapy, etc.)* and after-effects.

Year	Illness or problem	Intervention	After-effects

4- ADDITIONAL DATA

Approximate weight:..... Approximate height:..... Allergies:.....

B.P.:..... Possibility of orthostatic hypotension: ☐yes ☐no

Wounds: location..... duration:.....

description *(dimension/seriousness)* ..... weeping wound: ☐yes ☐no

Habits	No	Yes	Give details of any problem *(physical, mental, social)* related to this habit
Tobacco use			
Consumption of alcohol			
Drug abuse (prescribed or not)			
Poor nutrition			

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MÉDECIN

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..

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)

FECAL INCONTINENCE *(Frequency, recurring or permanent.)*

ABILITY TO COMMUNICATE *(Specify the diagnosis associated with the handicap)*

Eyesight:

Hearing:

Speech:

MENTAL FUNCTIONS

Cognitive *(orientation, memory, judgment, concentration, comprehension)*

Affective *(temperament, emotions, will, etc.)*

BEHAVIOUR *(agressiveness, violence, tendency to give way to fugue, exhibitionism, etc.)*

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MÉDECIN

6- RELEVANT REPORTS FROM COMPLEMENTARY EXAMINATIONS AND CONSULTATIONS

(Laboratory, X-ray, physiotherapy, neurology, psychiatry, etc. Attach report, if deemed advisable.)

7- PROPOSED INTERVENTIONS

A. MEDICATION For each prescription medicine, provide

Name - dose - posology - how administered - anticipated duration

Has the beneficiary been observed to have difficulty administering his medication? ☐ yes ☐ no

If yes, specify:

B. FOOD AND DIET

☐ balanced ☐ high fibre content ☐ low sugar ☐ no salt

☐ other, specify

C. CARE/SERVICES

	No	Yes	If yes, specify the care/service needs and restrictions
• physiotherapy			
• ergotherapy			
• respiration therapy			
• oxygen therapy			
• speech therapy			
• specific nursing care			
• social service			
• other(s)			

D. OTHER *(further assessment, etc.)*

Comments:

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D. OTHER *(further assessment, etc.)*

Comments:

8- PROGNOSIS

The beneficiary's { **biological condition is** ☐stable ☐unstable; **psychological condition is** ☐stable ☐unstable; **social condition is** ☐stable ☐unstable }

What is your prognosis as to how his biological, psychological and social condition can be expected to change?

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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): .....

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10- OTHER INFORMATION DEEMED IMPORTANT OR SPECIFIC RECOMMENDATIONS BY THE PHYSICIAN

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Are you the beneficiary's physician? ☐yes ☐no How long have you known him? _____

Did you have the necessary medical information when you performed your assessment? ☐yes ☐no

_____ Physician's signature _____ Date

11- BENEFICIARY'S AUTHORIZATION

I authorize _____ to release the information contained in
name of physician

this form to the persons responsible for evaluating my application for services.

_____ Beneficiary's signature (IN CASE OF INCAPACITY) _____ Signature of legally authorized person _____ Capacity

_____ Witness

_____ Date of authorization

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The beneficiary's { **biological condition is** ☐stable ☐unstable; **psychological condition is** ☐stable ☐unstable; **social condition is** ☐stable ☐unstable }

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