HEALTH ASSESSMENT

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

Practice Record

All		Aboriginal & Torres Strait Islander	
Practice	Home	Practice	Home
Item 700 ☐	Item 702 ☐	Item 704 ☐	Item 706 ☐

PATIENT NAME _____

DOB _____ Male ☐ Female ☐

Name & contact details of carer _____

Medical Practitioner

Medical record/file No. 19/03/01

Is this patient a carer? Yes ☐ No ☐

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

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

Health Assessment at Practice ☐

Home Visit ☐

CURRENT HEALTH / RELEVANT FAMILY HISTORY

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

COMMUNITY / ALLIED HEALTH SERVICES

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
- ☐ 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	reason

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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 Y ☐ N ☐

PHYSICAL ACTIVITY

6 Do you **exercise** at least 30 minutes a day, most days Y ☐ 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 ☐
Pulse rate _____

Comments

Consider check for postural hypotension Y ☐ N ☐

GENERA

11 Comments

OTHER F

12 Oral Health

Comments eg teeth, gums, dentures

13 Feet
Problems with one or both feet? Y ☐ N ☐

Comments

14 Vision
Acuity (with glasses) _____

Comments

15 Hearing

a Whisper test — Heard ☐ Not heard ☐

Comments

b Hearing aid — N/A ☐ Adequate ☐ Poor ☐

c Check ear canals — Normal ☐ Abnormal ☐

16 Fit to drive Y ☐ N ☐
Comments

Refer AustRoads Guidelines

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NUTRITION

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

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 ☐

INDEPENDENCE / SOCIAL SUPPORT

19 Are you living

Alone ☐
As a couple ☐
With others ☐

Comments

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 ☐

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 ☐ N ☐

e Referral to Allied health required? Y ☐ N ☐

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 ☐

b Have you had any difficulty sleeping? Y ☐ N ☐

Details:

Consider Geriatric Depression Scale Y ☐ N ☐

Comment

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CONTINENCE

22 Continence

Leaking urine? Never ☐ Sometimes ☐ Often ☐

Is this related to coughing or sneezing? Y ☐ N ☐

Faecal soiling/change of bowel habit Never ☐ Sometimes ☐ Often ☐

Comment

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 ☐ N ☐

Can you get in and out of bed easily and safely? Y ☐ N ☐

Can you switch on a light easily from your bed? Y ☐ N ☐

Can you get on an off the toilet easily and safely? Y ☐ N ☐

Are all loose mats and floor coverings securely fixed to the floor? Y ☐ N ☐

Do you use slip resistant mats or self-adhesive non slip strips in the bath/bathroom/shower recess? Y ☐ N ☐

Can you carry meals easily and safely from the kitchen to your dining area? Y ☐ N ☐

Are you able to grip and use utensils efficiently and safely? Y ☐ N ☐

Are the edges of the steps/stairs easily identifiable? Y ☐ N ☐

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

FUNCTIONAL ACTIVITIES

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 ☐ N ☐

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 ☐

Are your walkways inside and outside the house free of cords and clutter? Y ☐ N ☐

Is all the household lighting adequate for you to see clearly? Y ☐ N ☐

Have you been free of falls in the home in the past 3 months? Y ☐ N ☐

Actions suggested

MEDICATION REVIEW

25 Complete the separate Medication Review Sheet

Comment

RELEVANT PREVENTIVE CARE CHECKLIST

26 Vaccinations **date**

Influenza ☐
Pneumococcus ☐
Tetanus ☐
Other ☐

Comments

27 Other areas for examination and or follow up

eg Pap smears, weight bearing exercise

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PATIENT NAME _____ DOB _____ Carer _____

HEALTH ASSESSMENT HISTORY

Is this the only health assessment the patient has undertaken in the last 12 months Y ☐ N ☐ If so, by whom _____

Is patient eligible under Veterans' Affairs Y ☐ N ☐ If yes, please ensure this form is available on request from DVA

GOALS OF PATIENT AND 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*) / /