Informatix Health Care Plan Assessment

* Indicates required question

1. Email *

Introduction and Consent

Purpose of the Assessment: Explain the goals and process.**Consent for Assessment**: Secure the patient's consent, ensuring they understand the purpose and their rights.

2. **Did you understand the purpose of this assessment?** *

Mark only one oval.

- Yes'
- No
- Option 3

3. **Do you consent to participate?** *

Mark only one oval.

- Yes
- No

Personal Information:

4. **Irene Phipps** *

5. **10/26/1973** *

Example: January 7, 2019

6. **1640 Worcester road apt 508d Framingham MA 01702** *

7. **3392031003** *

8. **irenee1026@aol.com** *

9. **Kenneth Fettinger** *

10. **Spouse** *

11. **3392031003** *

12. **Natalia Rosenburg** *

13. **5085320223** *

14. **Other Healthcare Providers** *

Mark only one oval.

- ◯ Physical Therapist
- ◯ Specialist
- ◯ Therapist
- ◯ Other: _____

Medical History

15. **Propranolol 60 mg q day for migraines** *

_____

_____

_____

_____

_____

16. **Migraines, right ankle fractur, C section x2** *

_____

_____

_____

_____

_____

17. **Migraines, right ankle fractur, C section x2** *

_____

_____

_____

_____

_____

18. **Propranolol 60mg q day migraines** *

19. **Medications:** Complete list with dosages and reasons for use and schedule

20. **1 year ago a normal CBC**

21. **None** *

Functional Independence Measure

Mobility, Self-Care, Vision, Hearing, Cognitive Function.

22. **Ability to walk** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Use of Walker
- ◯ Use of Wheelchair
- ◯ Bed Bound
- ◯ Option 6
- ◯ Other: _____

23. **Ability to climb stairs** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Cannot Climb
- ◯ Other: _____

24. **Transfers: Bed, Chair, Wheelchair** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

25. **Transfers: Toilet:** *

Mark only one oval.

- ◯ independent
- ◯ Needs Assistance
- ◯ Other: _____

26. **Transfers: Shower/Bath:**

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

27. **Bathing:** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

28. **Toileting:** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

29. **Bladder Management:** *

Mark only one oval.

- ◯ Continent
- ◯ Incontinent
- ◯ Other: _____

30. **Bowel Management:** *

_____

31. **Grooming** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

32. **Upper Body Dressing:** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

33. **Lower Body Dressing:** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

34. **Ability to Prepare Meals:** *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Option 3

35. **Ability to Eat** *

Mark only one oval.

	1	2	3	4	5	
Poo	◯	◯	◯	◯	◯	Excellent

36. **Can Swallow Safely** *

Mark only one oval.

- ◯ Yes
- ◯ No

37. **Housekeeping** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

38. **Laundry** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

39. **Shopping** *

Mark only one oval.

- ◯ Independent
- ◯ Needs Assistance
- ◯ Other: _____

40. **Ability to Express Needs** *

Mark only one oval.

	1	2	3	4	5	
Poo	◯	◯	◯	◯	◯	Excellent

41. **Ability to Understand Instructions** *

Mark only one oval.

	1	2	3	4	5	
Poo	◯	◯	◯	◯	◯	Excellent

42. **Can Drive** *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Other: _____

Normal

43. **Living Situation:** Do you live alone, with family, assisted living, etc *

Check all that apply.

- ☐ Alone
- ☐ Family
- ☐ Assisted Living
- ☐ Hospital
- ☐ Other: _____

44. **Social Support Network:** Family, friends, community groups *

Check all that apply.

- ☐ Family
- ☐ Friends
- ☐ Groups
- ☐ Other: _____

45. **Embroidery, cooking shows** *

46. **Emotional and Mental Health:** Mood, anxiety, depression, cognitive function *

Check all that apply.

- [ ] Mood Disorder
- [ ] Anxiety
- [ ] Depression
- [ ] Stress
- [ ] Sleep Well
- [ ] Other: _____

47. **Spiritual Beliefs and Practices:** Importance of faith or spirituality in life

48. **How would you describe your current health status?** *

49. **Beyond health, what personal interests or activities are important to you?** *

Goals and Preferences:

50. **Short-Term Goals:** What does the elder want to achieve in the next few months?

51. **Long-Term Goals:** What are the elder's hopes and aspirations for the future?

52. **Care Preferences:** Level of assistance desired *

Mark only one oval.

- Partial
- Full
- Non
- Other: _____

53. **What self-care tasks are you able to perform independently?** *

54. **What can we do to support and enhance your independence in daily living?**

55. **What areas of your condition or care do you need more information about?** *

56. **What is your preferred method of receiving health-related information?** *

57. **Do you have any specific cultural or linguistic needs we should be aware of in your care?**

Legal Considerations

58. **Are you familiar with your rights and protections under Massachusetts elder law?** *

Mark only one oval.

- Yes
- No
- Other: _____

59. **Do have a Healthcare Proxy?** *

Mark only one oval.

- Yes
- No

60. **Name of Healthcare Proxy**

61. **Phone Number** *

62. **Do You Have a Power of Attorney** *

Mark only one oval.

- Yes
- No

63. **Name of Your Power of Attorney**

64. **Phone Number**

Coordinated Care Plan

65. **Who are the current members of your healthcare and support team?** *

66. **How should we coordinate your care with other services you receive?** *

67. **What is your plan in case of a health emergency?** *

68. **Do you have an evacuation plan?** (give me a copy) *

Mark only one oval.

- Yes
- No

69. **Who is the Emergency Contact?** *

70. **Phone Number?** *

Personalized Care Planning

71. **What does your typical daily routine look like, and what are your preferences?** *

72. **Do you have any specific dietary needs or restrictions?** *

73. **Are there any spiritual or cultural practices that we should consider in your care plan?** *

Strengths and Abilities Focus

74. **What personal strengths and abilities would you like us to recognize in your care plan?** *

75. **How can we help you develop or maintain these strengths and abilities?** *

Review and Feedback

76. **What specific actions have we agreed upon today for your care plan? Write a summary**

77. **When should we schedule a review of your care plan?** *

Example: January 7, 2019 11:03 AM

78. **How would you prefer to provide feedback on the care you receive?** *

Mark only one oval.

- Email
- Phone
- Other:

79. **How did you hear about us ? ***