AGED CARE ASSESSMENT FORM

SWARG™ COMMUNITY CARE
Connecting People, Enriching Health

NAME							
PHONE				**EMAIL**			
PATIENT NAME							
AGE		**GENDER**		**LIVES IN**		**RELATION**	
DIAGNOSIS							

Please indicate all requirements with rating 1 to 4.

QUES	CARE REQUIREMENTS	RATINGS			
		Independent 1	**Some Assistance 2**	**Frequent Assistance 3**	**Total Assistance 4**
Q.1	Mobility				
Q.2	Toileting				
Q.3	Feeding				
Q.4	Showering				
Q.5	Dressing/grooming				
Q.6	Medication				
Q.7	Cleaning teeth				
Q.8	Transfer bed to chair				
Q.9	Physio Care Required				
Q.10	Special Diet Required	Peg feeding	Ryle's tube	Soft diet	Liquid diet
Q.11	Behavior Problem	Nil	Occasionally	Often	Always
Q.12	Psychiatric Problem	Nil	Mild	Moderate	Severe
Q.13	Mobility Aids Required	Not applicable	Types of aid used e.g. walker, stick, wheelchair		
Q.14	Bed sores care	Present	Absent	Present sites	
Q.15	Vision	Satisfactory	Partial impaired	Total blindness	
Q.16	Hearing	Satisfactory	Partial deafness	Total deafness	
Q.17	Speech	Satisfactory	Slurred	Aphasic	
Q.18	Route For Medication	Oral	Injected	IV/IM	Other route
Q.19	Current Medical Conditions				
Q.20	Financial support by	Patient	Family member	Relative	Sponsor
OFFICE USE ONLY		□ CRITICAL CARE	□ HIGH CARE	□ MEDIUM CARE	□ LOW CARE

Thank you for your time to filled out assessment form. We will get back to you soon.