Capital Health

Comprehensive Geriatric Assessment Form

WNL = Within Normal Limits ASST = Assisted IND = Independent DEP = Dependent

○ **Cognition** ☐ WNL ☐ CIND ☐ MCI ☐ Dementia ☐ Delirium MMSE: _____ FAST: _____
Chief lifelong occupation: _____ Education (years): _____

○ **Emotional** ☐ WNL ☐ ↓ Mood ☐ Depression ☐ Anxiety ☐ Fatigue ☐ Hallucination ☐ Delusion ☐ Other

○ **Motivation** ☐ High ☐ Usual ☐ Low **Health Attitude** ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Couldn't say

○ **Communication** **Speech** ☐ WNL ☐ Impaired **Hearing** ☐ WNL ☐ Impaired **Vision** ☐ WNL ☐ Impaired

○ **Strength** ☐ WNL ☐ Weak Upper: PROXIMAL DISTAL Lower: PROXIMAL DISTAL

○ **Exercise** ☐ Frequent ☐ Occassional ☐ Not

		BASELINE (two weeks ago)	CURRENT (today)	NOTES
○ **Balance**	Balance	WNL Impaired	WNL Impaired	
	Falls	N Y Number _____	N Y Number _____	
○ **Mobility**	Walk Outside	IND ASST Can't	IND ASST Can't	
	Walking	IND SLOW ASST DEP	IND SLOW ASST DEP	
	Transfers	IND Stand by ASST DEP	IND Stand by ASST DEP	
	Bed	IND PULL ASST DEP	IND PULL ASST DEP	
	Aid	None Cane Walker Chair	None Cane Walker Chair	
○ **Nutrition**	Weight	GOOD UNDER OVER OBESE	STABLE LOSS GAIN	
	Appetite	WNL FAIR POOR	WNL FAIR POOR	
○ **Elimination**	Bowel	CONT CONSTIP INCONT	CONT CONSTIP INCONT	
	Bladder	CONT CATHETER INCONT	CONT CATHETER INCONT	
○ **ADLs**	Feeding	IND ASST DEP	IND ASST DEP	
	Bathing	IND ASST DEP	IND ASST DEP	
	Dressing	IND ASST DEP	IND ASST DEP	
	Toileting	IND ASST DEP	IND ASST DEP	
○ **IADLs**	Cooking	IND ASST DEP	IND ASST DEP	
	Cleaning	IND ASST DEP	IND ASST DEP	
	Shopping	IND ASST DEP	IND ASST DEP	
	Medications	IND ASST DEP	IND ASST DEP	
	Driving	IND ASST DEP	IND ASST DEP	
	Banking	IND ASST DEP	IND ASST DEP	

○ **Sleep** ☐ Normal ☐ Disrupted ☐ Daytime drowsiness **Socially Engaged** ☐ Frequent ☐ Occassional ☐ Not

○ **Social** ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Lives ☐ Alone ☐ Spouse ☐ Other

Home ☐ House (Levels___) ☐ Steps (Number ___) ☐ Apartment ☐ Assisted Living ☐ Nursing home ☐ Other

Supports ☐ Informal ☐ HCNS ☐ Other ☐ Req. more support ☐ None

Caregiver Relationship ☐ Spouse ☐ Sibling ☐ Offspring ☐ Other

Caregiver Stress ☐ None ☐ Low ☐ Moderate ☐ High

○ **Advance directive in place?** ☐ Yes ☐ No

○ **Code Status** ☐ Do not resuscitate ☐ Rescuscitate

Caregiver occupation (CG): _____

Patient contact:
☐ Inpatient ☐ Clinic ☐ GDH ☐ NH ☐ Outreach ☐ Home ☐ Assisted Living ☐ ER ☐ Other

PT = PATIENT
CG = CAREGIVER

Current Frailty Score:

Scale	PT	CG
1. Very fit		
2. Well		
3. Well with Rx'd co-morbid disease		
4. Apparently vulnerable		
5. Mildly frail		
6. Moderately frail		
7. Severely frail		
8. Very severely frail		
9a. Terminally ill - walker		
9b. Terminally ill - bed		

● **Action Required**
○ **Monitor**

ACTION REQUIRED (check appropriate circles)

Problems:	Med adjust req.	Associated Medication: (*mark meds started in hospital with an asterisk)
1. _____	○	_____
2. _____	○	_____
3. _____	○	_____
4. _____	○	_____
5. _____	○	_____
6. _____	○	_____
7. _____	○	_____
8. _____	○	_____
9. _____	○	_____
10. _____	○	_____
11. _____	○	_____
12. _____	○	_____

Assessor/Physician: _____ Date: _____ (YYYY/MM/DD)