**CAREGIVER’S CARE MANAGEMENT ASSESSMENT**

|  |  |  |
| --- | --- | --- |
| Name:  | Age:  | DOB:  |
| Relative’s Name:  | Tel:  |
| Date of Completion:  | Health Ins::  |

1. **SELF-CARE ABILITIES**

|  |  |
| --- | --- |
| Please check if a problem. | COMMENTS |
|   | Going to the toilet alone. |   |
|  | Taking a bath or shower |   |
|  | Dressing |   |
|  | Eating |  |
|   | Walking where he/she wants to go |  |
|  | Grooming |  |
|  | Using the phone to call others |   |
|  | Paying bills and handling finances |   |
|  | Cleaning house |   |
|  | Doing laundry |   |
|  | Shopping for food and routine items |  |
|  | Preparing meals |  |
|  | Getting out of the house and socializing |   |
|  | Using some form of transportation to get to a desired location |  . |
|  | Taking medicine |   |
|  | Performing usual hobbies, work and/or volunteer activities |   |
| *Comments:*  |

1. **MEMORY / THINKING / REASONING ABILITIES**

Please check if there are problems with remembering:

|  |  |
| --- | --- |
| Problems | COMMENTS |
|   | Things he/she has been told in the previous 5-10 minutes |   |
|  | Events of the past week or month |  |
|  | Events long past (more than one year) |  |
|  | Names of friends |  |
|  | Names of close family members |  |
|  | Words he/she wants to say |  |
|  | The current season ,year, month, or day of week |   |
|  | Appointments or scheduled events |  |
|  | How to do things he/she used to know how to do, such as using a sewing machine or driving a car |  . |
|  | Where he/she lives |  |
|  | Personal events (things that have happened during his/her lifetime, especially a long time ago) |  |
|  | Where he/she put things |  |
|   | What he/she is doing or talking about (repeats self) |  |
|  | To take medicine |   |
|  | To secure home/care when vacated, to turn off the stove, etc. |   |
| *Comments:*  |

1. **BEHAVIOR**

Please check the items that describe any behavior problems:

|  |  |
| --- | --- |
| Problems | COMMENTS |
|   | Has withdrawn from one or more usual and enjoyed activity |   |
|  | Has become lost in a familiar area |  |
|  | Wanders aimlessly, especially at night |  |
|  | Becomes agitated, especially in the evening |  . |
|   | Strikes out at you or others or becomes combative in other ways |   |
|  | Dresses inappropriately |  |
|  | Uses too much alcohol |   |
|  | Has greater than usual difficulty getting along with friends, relatives and others |  |
|  | Takes medicines inappropriately – too much/little, buys own medicine or trades with others |  |
|  | Accuses others of stealing or doing something ‘bad’ to him/her |  |
|  | Spends long hours in bed |  |
|  | Bathes too infrequently |  |
|  | Sleeps frequently during the day |   |
|  | Has interrupted sleep pattern |   |
|  | Awakens early and cannot get back to sleep |   |
|  | Has shown a change in handwriting |   |
|  | Does anything not consistent with typical behavior |  |
|  | Refuses to eat nutritious food/meals or complains of poor appetite |  . |
|   | Complains of trouble with memory |   |
| *Comments* |

1. **MOOD**

Please check the items that describe mood or feelings:

|  |  |
| --- | --- |
| Problems | COMMENTS |
|   | Suspiciousness / mistrust of others |   |
|  | Unusual lack of concern about him/herself or others, and/or events |  |
|  | Loss of interest in usual concerns |  |
|   | Worry, anxiety or nervousness |   |
|  | Anger |   |
|  | Hallucinations – seeing, hearing, feeling or smelling things that are not there |  |
|  | Frequent or sudden mood change |  |
|  | Inappropriate laughing or crying |  |
|   | Sadness |  |
|  | States he/she wishes he/she were dead or talks about suicide |  |
| *Comments:*  |

1. **DESCRIBE CURRENT LIVING SITUATION AND HOW A TYPICAL DAY IS SPENT**

Current living arrangements (social supports, hobbies, regularly scheduled activities, ability to access transportation and services, type of dwelling or residence)

|  |  |
| --- | --- |
| Rising time:  | Bed time:  |

|  |
| --- |
| What does she do during: |
| Morning hours:  |   |
| Afternoon hours: |   |
| Evening hours: |   |

1. **ADDITIONAL INFORMATION**
2. **Please indicate the name and address of his/her principal physician**:

1. **List current health problems / diagnoses and other significant medical history.**
2. **List current medications (prescription, over the counter, vitamins, laxatives), dosage and why taken**.
3. **Indicate nutritional status – special diet, eating problems, etc.**
4. **List any assistance devices used (cane, walker, wheelchair, etc.) and any other medical supplies utilized (supplemental oxygen, commode chair, hospital bed, etc.)**
5. **Comment on vision or hearing difficulties**.
6. **Please indicate main insurance and supplemental health policies, long term care policies, Veterans status.**.
7. **Please indicate monthly income and source and approximate resources / assets (savings, property, etc.).**
8. **Briefly describe your loved one’s social history and background (birthplace, where family lived, marriages, children, occupation, interests, retirement, etc.). How would you characterize social relationships?**
9. **Legal : Check if you have these documents. Indicate who is power of attorney.**

**Health Care Power of Attorney**:

**Durable Financial Power of Attorney**

**Directive to Physicians**

**Last Will & Testament**

**Out of Hospital DNR**

1. **Other family members, support people, and agency services.**
2. **Additional comments about your loved one’s needs**; **goals for consultation**.