DOCTOR'S ASSESSMENT FORM

FACILITY NAME: Stillwater Gardens Rest Home & Continuing Care

CLIENT NAME:________________________ D.O.B:____________________

ADDRESS:________________________
_______________________________ PHONE:____________________

NEXT OF KIN /ADVOCATE:____
ADDRESS:________________________
____
_______________________________ PHONE:____________________
RELATIONSHIP: __________________

DOCTORS ASSESSMENT (Please answer all questions)

1) Are you the applicant's usual G.P.?______________________________

2) If so, how long have you known the patient?________________________

3) When did you last see the patient?______________________________

4) Do you wish to continue to have over sight of the patient?_____________

5) Has patient been in any other residential care facility/ Hospital within the last 5 years?____
   Name of Hospital:________________________ Approx Dates:__________

Please list:

1) All Diagnosis:____
____
____
____

2) Any Drug Allergies:____
____

3) Present Drug Regime:____
____
____
____
____

Physical State: (circle and comment where applicable)

Mobility: Normal With help only Unable to walk
Aids used:____

Speech: Normal Aphasic Language barrier

Bowel: Continent Occasionally incontinent Incontinent

Bladder: Continent Occasionally incontinent Incontinent
Aids used:____

Sight: Good Poor Blind
Aids used:____

Diet: Normal________________ Special (specify)____________________

Feeds: Without help With help
Aids used:____

Sleeps: With drugs Without drugs
Comments:____

Hygiene: Independent Partial assistance Full assistance
Comments:____

Skin Integrity: e.g. bed sores, rash etc____________________________

Mental State: **(Circle where applicable)**
Normal Confused Depressed Aggressive Wanders Hallucinations
Paranoia
Degree of above: Slight or marked Occasionally Usually
Comments:____

Social Circumstances: (Home conditions, family and community support, domiciliary services provided, other agencies involved)

____
____
____

Reason for Referral:____
____
____

Circle if admission required: Within 24 hours / within 1 week / no immediate hurry
(Circle)

placement for long-term / short term

Other General Comments: ____
____
____
____
____
____
____
____
____
____
____
____

Doctors Name:_________________________
____**Phone:**_____________________________

Signature:____________________________

Date: ___________________