Wintec | Te Pūkenga

TE KOTAHI ORANGA

Health and Wellness Centre

INITIAL ASSESSMENT FORM

Use as paper template during assessments for scribbling notes, but ultimately enter the data into replica template on PMS patient file electronically.

Staff/students undertaking the assessment today:	**Name**	**Role**
More boxes open as needed		
Client/whānau and others present:	**Name**	**Relationship to client/whānau**
More boxes open as needed		

Hui/Consult process

- Mihimihi
- Whakawhanaungatanga
- Kaupapa
- Poroporoaki

SUBJECTIVE ASSESSMENT

Quick check for orientation

Ask client/whānau 'what is today's date'**:** ...../...../..... ☐ Correct ☐ Incorrect
Notes: .....

Do you have any problems with understanding or remembering instructions given to you?: ☐ Yes ☐ No

Notes: .....

Do you wear glasses?: ☐ Yes ☐ No
Date of last eye exam: ...../...../..... (single date field ok) ☐ Don't know

Do you wear hearing aids?: ☐ Yes ☐ No
Date of last hearing exam: ...../...../..... (single date field ok) ☐ Don't know

Cultural factors/beliefs

In your culture are there some health practices that are important to you? ☐ Yes ☐ No
Notes**:** .....

Is faith or spiritualty important to you? ☐ Yes ☐ No
Notes**:** .....

Are you part of any religious or spiritual community or congregation? ☐ Yes ☐ No
Notes**:** .....

Current diagnosis

☐ Asthma ☐ COPD ☐ Type 2 Diabetes ☐ Falls ☐ Cancer rehab ☐ Other

Other (specify): .....

Date diagnosed: ...../...../..... Date of last medical annual review: ...../...../..... ☐ Don't know
(single date fields ok)

Current concerns: .....

Client/whānau goals/expectations from Te Kotahi Oranga visit (formulate into three reasonable goals to achieve):

1. .....
2. .....
3. .....

More lines as needed

Medical history

Do you have any other medical conditions?: ☐ Yes ☐ No
Notes**:** .....
.....

Do you have any known allergies *(including drug allergy, food allergy or intolerances)*?*:* ☐ Yes ☐ No
Notes**:** .....

Have you experienced any significant surgical, trauma, hospitalisation in your past?: ☐ Yes ☐ No

Tell me about this**:** .....
.....

Family/whānau history

Does anyone in your immediate whānau have any significant medical problems, such as:

☐ Asthma ☐ Heart problems ☐ Cancer ☐ Diabetes ☐ Mental Illness ☐ Other

Notes**:** .....
.....

Medications

Name and strength of medication	**Dose and frequency**
More boxes open as needed	More boxes open as needed

Medication adherence

Who administers the dose each day?: ☐ Self ☐ Partner/Carer

Notes: .....

Who organises repeat prescriptions and collects your medications from the pharmacy? ☐ Self ☐ Partner/Carer
Notes: .....

Say: *Remembering to take medicine at the right times can be really hard, and many people miss a dose here and there. How do you get on with your medicine? Do you miss any doses?*

Are there any missed doses per week?: ☐ Yes ☐ No

If yes, how many: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7+

Medication technique: ☐ Discussed and demonstrated ☐ Discussed only

Notes: .....

Social History

Occupation

Are you:

☐ Retired Previous occupation: .....

☐ Employed (specify hours/type):

Home and support

Do you:

☐ Live alone

☐ Have help at home *(specify)*

☐ Other (e.g. retirement home, assisted living)

Notes: .....

Would you describe your house as:

☐ Warm, dry and well-insulated

☐ Cold, damp and uninsulated

Notes: .....

Is your home:

☐ Single level ☐ Two-story

Do you have:

☐ Stairs in the house ☐ Stairs outside house (e.g. for access)

☐ Pet(s) in the house *(specify)*: .....

Do you have any handrails in your house? ☐ Yes ☐ No

Other access/falls risk issues to note: .....

Feeling safe at home:

Have you ever felt unsafe at home? ☐ Yes ☐ No

Notes**:** .....

Do you ever feel that you have no choice or control in family decision-making? ☐ Yes ☐ No

Notes**:** .....

Do you ever feel humiliated or demoralised by your partner/husband/wife? ☐ Yes ☐ No

Notes**:** .....

During altercations, have you ever felt fearful? ☐ Yes ☐ No

Notes**:** .....

An answer of 'Yes' to any of these questions is an automatic referral to social worker

Support network *(any family nearby, neighbours, support groups):*

Tell me about your support network. Do you have family nearby? Neighbours you can rely on? Do you belong to any social/support groups? .....

Social interests/hobbies

Tell me about your social interest and hobbies, things you like to do: .....

Nutrition

Have you noticed any change in your weight in the last 3 months?: ☐ Yes ☐ No
Tell me about this: ....

Do you have any problems with your teeth and gums that affects swallowing or eating?: ☐ Yes ☐ No

Last dental check up: ...../...../..... (single date field ok) ☐ Don't know
Notes: .....

Who is the person who does the grocery shopping?:

☐ Self ☐ Someone else

Notes: .....

Who is the person who prepares the meals?:

☐ Self ☐ Eats mainly takeaways ☐ Someone else prepares meals

Notes: .....

What is a typical description of your *(include type/quantity, e.g. white or brown bread and how many slices):*

Breakfast: .....

.....

Lunch: .....

.....

Evening meals: .....

.....

Snacks: .....

Fluid intake: .....

Alcohol consumption:
Do you consume more than 2 alcoholic drinks in a day/evening OR drink more than 5 days in a week? ☐ Yes ☐ No
Notes and history of use: .....

Overall rating of meals based on description e.g.:

- Dinner: 'half plate' vegetables, ¼ plate protein, ¼ plate carbs
- Snacks: low sugar, low carbs, high grains, fruit and protein
- Lunch and breakfast: low sugar, low carbs, high protein, fruit and protein

Client/whānau perception of what they eat:

☐ Mostly healthy ☐ Needs improvement ☐ Unhealthy

Assessor perception of what client/whānau eats:

☐ Mostly healthy ☐ Needs improvement ☐ Unhealthy

Notes: .....

Exercise and activity

Are you able to walk for longer than 30 minutes in one session?: ☐ Yes ☐ No ☐ Don't know

If not, what stops you?: ☐ Pain ☐ Shortness of breath ☐ Cramp ☐ Other: .....

How do you normally get to places (e.g. uses car with valid license, car, bus, etc)?: .....

How many times a week are you active (activities that increase working of breathing)?:

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

How long are you active for per session?:

☐ Less than 30 mins ☐ 30-45 mins ☐ 1 hour or longer

Notes: .....

What kind of activity do you do?:

☐ Walking ☐ Jogging/Running ☐ Gym class ☐ Bike ☐ Swim ☐ Housework/outside tasks

☐ Other *(Specify)* .....

Sleep

How many hours sleep do you get a night?: ☐ Less than 4 ☐ 4-6 ☐ 7+

Do you experience any breathlessness at night?: ☐ Yes ☐ No

How many pillows do you use?: ☐ 1 or none ☐ 2-3 ☐ More than 3

Has anyone ever told you, or have you experienced, episodes of stopping breathing in your sleep?: ☐ Yes ☐ No

Do you experience constant waking at night/insomnia?: ☐ Yes ☐ No

Notes/concerns: .....

Mobility

Do you have any problems with your mobility (getting around, out of a chair, on/off toilet etc)?: ☐ Yes ☐ No

Notes: .....

Do you use a mobility aid?: ☐ Yes ☐ No

☐ Walking stick ☐ Walking frame ☐ Scooter ☐ Other .....

Pain

Do you expereince any pain anywhere in your body?: ☐ Yes ☐ No

If yes - tell me about your pain (where, how bad, how long etc) .....

Smoking/vaping history

Does anybody in the home smoke or vape?: ☐ Yes ☐ No

Who smokes/vapes in the home?: .....
(If it is the client, ask 'are you ok to tell me more about it?' and fill in 'currently smoking/vaping' info)

(If client answers 'no' to previous question)

Have you ever smoked/vaped?

☐ Never smoked/vaped
☐ Ex-smoker
Smoking history: .....
☐ Smoke exposed/previously smoke exposed
Smoke exposed history: .....

☐ Currently smoking
Amount/frequency/plans to quit: .....

Quitting advice ☐ Accepted ☐ Declined
Advice given: .....

☐ Currently vaping
Amount/frequency/plans to quit: .....
.....

Quitting advice ☐ Accepted ☐ Declined
Advice given: .....

Do you use recreational drugs?: ☐ Yes ☐ No

Notes and history of use: .....

Mental well-being

Would you say you are experiencing a high level of stress in your life right now?: ☐ Yes ☐ No
Please tell me more, if you would like to: .....

Do you ever have feelings of not coping or deep sadness?: ☐ Yes ☐ No
Please tell me more, if you would like to: .....

Have you ever experienced significant mood changes?: ☐ Yes ☐ No
Please tell me more, if you would like to: .....

Financial

Because of limited income or financial difficulties, during the past month have you struggled to purchase:

☐ Food ☐ Medical care ☐ Medications or supplies ☐ Transport

Please tell me more, if you would like to: .....

OBJECTIVE ASSESSMENT

Blood Pressure

BP sitting	BP 5 min lying down	BP 1 min standing	BP 3 min standing
BP ..... /	BP ..... /	BP ..... /	BP ..... / .....
PR	PR	PR	PR .....
SPO_2	SPO_2	SPO_2	SPO_2 .....

Reduction in systolic BP of ≥ 20 mmHg or in diastolic BP of ≥ 10 mmHg within 3 mins of standing: ☐ Yes ☐ No

Light-headedness or dizziness on standing: ☐ Yes ☐ No
Notes: .....

Blood glucose	Lipids
HbA1c ..... mmol/mol (IFCC) ☐ Below 40 ☐ Between 40-50 ☐ Over 50 OR Random Blood Glucose (*people with diabetes only*): ..... mmol/L Last ate: ☐ < 1 hour ☐ 2-4 hours ☐ > 4 hours Notes:	Chol ..... mmol/L T G ..... mmol/L HDL ..... mmol/L LDL ..... mmol/L Non-HDL ..... mmol/L CHOL/HDL ..... Notes: .....

Have you experienced a hypoglycaemic incident within last 3 months (*people with diabetes only*): ☐ Yes ☐ No ☐ N/A

If yes, what happened to cause this?: .....

Cardiovascular Risk Assessment Score (https://cvdrisk.mohio.co.nz/): ..... %
(*people with diabetes only*):

Measurements

Weight (kg):	Height (m):	BMI (kg/m2):	Waist (cm): .....

Respiratory

Respiratory rate: ..... breaths/min

Any comments and observations about client/whānau breathing: .....

Do you experience any shortness of breath?: ☐ Yes ☐ No

If yes, mMRC Dysponea Scale score: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Tell me about this: .....

Do you experience any regular coughing?: ☐ Yes ☐ No

Tell me more about this (when, dry/wet, productive, any associated urinary incontinence): .....

Asthma *(people with asthma only)*

Asthma Control Test Score: (https://www.asthmacontroltest.com/)

☐ 20-25 well controlled
☐ 16-19 partly controlled
☐ 05-15 poorly controlled

How many times a week is the reliever medicine required?
(anything more than twice a week is a red flag) ☐ <1 ☐ 1-2 ☐ 3-4 ☐ 5+

Any need for oral steroids (e.g prednisone) since last visit?: ☐ Yes ☐ No

Notes: .....

Do you have an up to date Action Plan in place*?* *(people with asthma and COPD only):* ☐ Yes ☐ No

Cognitive screening

Mini-Ace Score: ☐ **Version A** ☐ **Version B** ☐ **Version C**

Attention: 0-4 ☐

Memory: 0-7 ☐

Fluency: 0-7 ☐

Visospatial: 0-5 ☐

Memory recall: 0-7 ☐

Total ☐ /30

Notes: .....

Falls Risk - screening

Have you ever experienced a fall?: ☐ Yes ☐ No

What happened?: .....

Number of trips, slips, falls or near falls, in last year: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+
Notes: .....

Are you able to get out of a chair without using hands? *(observe):* ☐ Yes ☐ No

Do you limit or avoid activities because you are afraid of losing balance or falling?: ☐ Yes ☐ No

Do you feel unsteady when you are standing or walking?: ☐ Yes ☐ No

Do you ever expereince dizziness e.g. with getting up, moving your head, turning, etc? ☐ Yes ☐ No

Notes: .....

Falls Risk Assessment

Timed up and go test ≥ 12 seconds: ☐ Yes ☐ No Time: ☐

30-second Chair Stand Test: Number: Below average score: ☐ Yes ☐ No

Four-stage Balance Test:

Parallel stance time: ☐ Less than 10 seconds?: ☐ Yes ☐ No

Semi-tandem stance time: ☐ Less than 10 seconds?: ☐ Yes ☐ No

Tandem (heel-toe) stance time: ☐ Less than 10 seconds?: ☐ Yes ☐ No

One-legged stance time: ☐ Less than 10 seconds?: ☐ Yes ☐ No

Client/whānau aged 65 years or older who do not progress to the tandem (heel-toe) stance or cannot hold this stance for at least ten seconds are at increased risk of falling.

Based on your findings, is this client/whānau a falls risk? ☐ Yes ☐ No

Six Minute Walk Test distance: ..... metres ☐ Not tested in this assessment

Romberg Test: ☐ Positive ☐ Negative ☐ Not tested in this assessment
Notes: .....

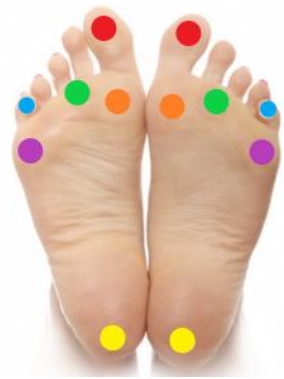
Foot assessment

Do you currently have any foot pain?: ☐ Yes ☐ No
Tell me about this: .....

Description of client/whānau footwear: .....

Does client/whānau have a good understanding of how to care for their feet?: ☐ Yes ☐ No

Left foot sensation



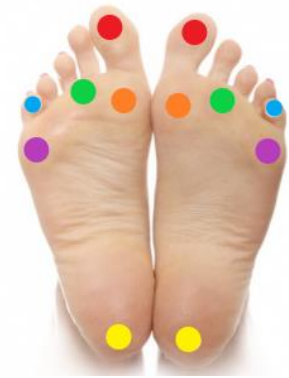
Touch Toe Test - sensation felt zones:
☐ Red
☐ Blue
☐ Green
☐ Orange
☐ Purple
☐ Yellow

Pulses felt:
☐ Dorsalis Pedis
☐ Posterior Tibialis

Observations:
☐ Warm and well perfused
☐ Cool and clammy
☐ Corns or callus
☐ Pathological nails
☐ Ulceration/previous ulcer
☐ Previous amputation
☐ Areas of poor skin integrity
☐ Presence of structural issues

Comments: .....

Right foot sensation



Touch Toe Test - sensation felt zones:
☐ Red
☐ Blue
☐ Green
☐ Orange
☐ Purple
☐ Yellow

Pulses felt:
☐ Dorsalis Pedis
☐ Posterior Tibialis

Observations:
☐ Warm and well perfused
☐ Cool and clammy
☐ Corns or callus
☐ Pathological nails
☐ Ulceration/previous ulcer
☐ Previous amputation
☐ Areas of poor skin integrity
☐ Presence of structural issues

Comments: .....

.....	.....
ANALYSIS *(taking into consideration client/whānau goals/expectations at the beginning of assessment)*	
Subjective findings of concern:	**Suggested plan for these areas of concern:**
More boxes open as needed	
Objective findings of concern:	**Suggested plan for these areas of concern:**
More boxes open as needed	
Overall impression:	
.....	
PLAN	
Recommendation to IP team going forward:	
.....	
Home visit recommended? ☐ Yes ☐ No	
Referrals required:	
.....	