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Self-Assessment DQ98 **Document Number: RM - 350**

Dear resident

Please complete your biographical data below and give us an accurate indication of various aspects of your health information and daily functionality on the second page. Please report any recent changes in your health status; such as new diagnoses, recent surgeries, etc. Assist your partner/spouse to complete the document as required. Any health data will be handled with strict confidentiality as per policy parameters.

DATE:

RESIDENT INFORMATION

Name:	
Surname:	
Email:	
Village:	
Unit No:	
Tel No:	
Cell No:	
ID No:	
Current Occupation:	
Hobbies:	

MEDICAL INFORMATION

Medical Aid:	
Plan:	
Medical Aid Number:	
Preferred Ambulance Service Provider:	
Preferred Hospital:	
Medical History/Chronic conditions:	
Recent changes in your health status such as new diagnoses, recent surgeries or procedures.	Describe:
Allergies/Special Alerts:	
Medication:	
Doctor:	Tel No:
Specialist Doctor:	Tel No:
Pharmacy:	Tel No:
Religion:	
Living Will: Yes/No	
Preferred funeral company:	

NEXT OF KIN

1. Name:	Relationship:
• **Email:**	
• **Tel no/Cell:**	
2. Name:	Relationship:
• **Email:**	
• **Cell:**	

RESIDENT ASSESSMENT-PLEASE TICK OFF THE MOST RELEVANT DESCRIPTION OF YOURSELF

1. Mobility

Can move independently, with or without appliances	
Require partial support or supervision	
Require full assistance	
Bedridden and totally dependent	

2. Personal Hygiene

Independent	
Require supervision or assistance	
Totally dependent	

3. Eating and Drinking

Independent	
Require supervision or assistance	
Must be fed	

4. Dressing

Independent	
Require supervision or assistance	
Totally dependent	

5. Vision

Satisfactory with glasses	
Impaired, require assistance	
Blind, fully dependent	

6. Hearing

Satisfactory	
Impaired, require hearing aids	
Deaf, fully dependent	

7. Medication

Can takes medication independently	
Require assistance	

8. Elimination

Full bladder and bowel control	
Require incontinence products	

9. Therapeutic Activities

Independently participate in activities	
Require assistance	

10. Mental Condition

Good memory and orientation	
Require support and supervision	

11. Specialized Care

None	
Require dressing or other special care	Describe:

12. General Functions

No caregiver required	
Requires some support or continuous assistance	Describe needs:

Signed by resident _____ **Date:** **Signed by village manager:** _____**Date:**

FOR OFFICE USE-Outcome will be explained by Evergreen Health as required
Total Care Needs: _____Functional Classification: _____