**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:**
 |  |
| 1. **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 |  |

1. **Eating and Drinking**

|  |  |
| --- | --- |
| Independent |  |
| Require supervision or assistance |  |
| Must be fed |  |

1. **Dressing**

|  |  |
| --- | --- |
| Independent |  |
| Require supervision or assistance |  |
| Totally dependent |  |

1. **Vision**

|  |  |
| --- | --- |
| Satisfactory with glasses |  |
| Impaired, require assistance |  |
| Blind, fully dependent |  |

1. **Hearing**

|  |  |
| --- | --- |
| Satisfactory  |  |
| Impaired, require hearing aids |  |
| Deaf, fully dependent |  |

1. **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_