PART ONE **CLIENT INFORMATION**

Northwest Territories Health and Social Services

CLIENT INFORMATION

NAME _____ _____ _____
FIRST MIDDLE LAST

MAIDEN _____ ALSO KNOWN AS _____

HEALTH CARE NO. _____ TREATY NO. _____ MARITAL STATUS: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Other _____

DATE OF BIRTH _____ AGE _____ GENDER ❑ M ❑ F
DAY MONTH YEAR

LANGUAGES

PREFERRED _____
❑ SPOKEN ❑ PARTIAL USE
❑ UNDERSTOOD

OTHER _____
❑ SPOKEN ❑ PARTIAL USE
❑ UNDERSTOOD

INTERPRETER NEEDED ❑ Y ❑ N

NAME _____ PH: _____

CURRENT RESIDENCE

ADDRESS _____
TOWN _____
PHONE _____
DIRECTIONS TO RESIDENCE _____

PERMANENT RESIDENCE

ADDRESS _____
TOWN _____
PHONE _____
DIRECTIONS TO RESIDENCE _____

REFERRAL DATA

SOURCE OF REFERRAL
❑ Physician _____ ❑ Health Care Worker _____
❑ Self ❑ Family Member _____
❑ Other (specify) _____

REFERRAL DATE:

REASON FOR REFERRAL

SERVICE REQUESTED

ANTICIPATED SERVICE NEEDS:

❑ LONG TERM CARE SERVICES
❑ ACUTE CARE SERVICES

❑ LESS THAN 3 MONTHS
❑ GREATER THAN 3 MONTHS

DATE / INITIAL

CONTACTS

NEXT OF KIN

NAME _____

ADDRESS _____

TOWN / CITY _____

PHONE (HM) _____

PHONE (WK) _____

RELATIONSHIP _____

EMERGENCY CONTACT

NAME _____

ADDRESS _____

TOWN / CITY _____

PHONE (HM) _____

PHONE (WK) _____

RELATIONSHIP _____

PRIMARY PHYSICIAN

Name _____

Clinic _____

Town _____

Phone _____

SPECIALIST

Name	Specialty	Contact Number

POWER OF ATTORNEY ☐ N/A

NAME

ADDRESS

CITY POSTAL CODE

PHONE (HM) PHONE (WK)

RELATIONSHIP

❑ LEGAL POWER OF ATTORNEY

❑ DOCUMENTS IN PROGRESS

GUARDIANSHIP ☐ N/A

NAME

ADDRESS

CITY POSTAL CODE

PHONE (HM) PHONE (WK)

RELATIONSHIP

❑ LEGAL GUARDIAN

❑ NO GUARDIAN

❑ APPLICATION IN PROGRESS

TRUSTEESHIP ☐ N/A

NAME

ADDRESS

CITY POSTAL CODE

PHONE (HM) PHONE (WK)

RELATIONSHIP

❑ LEGAL TRUSTEE

❑ APPLICATION IN PROGRESS

OTHERS FINANCIALLY RESPONSIBLE ☐ N/A

NAME

ADDRESS

CITY POSTAL CODE

PHONE (HM) PHONE (WK)

RELATIONSHIP

COMMENTS

PART TWO

FOCAL ASSESSMENT ACTIVITIES OF DAILY LIVING

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

	Eating	Dressing	Grooming	Bathing	Toileting Pericare	Oral Hygiene
INDEPENDENT						
Independent with devices						
Able to manage with setup						
Able to manage with some assistance client participates						
Unable to manage, needs constant supervision / assistance by one person						
Unable to manage, needs constant supervision / assistance by two people						

ONSET

- ❑ Chronic situation
- ❑ New change in situation
- ❑ Deterioration of situation

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

Further describe the client's situation / condition regarding the activities of daily living.

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Grooming aids
- ❑ Dressing aids
- ❑ Bathing aids
- ❑ Eating aids
- ❑ Other _____

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT ALLERGY MANAGEMENT

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the client's current allergic condition as it relates to the need to manage allergies.

ONSET

- ❑ Chronic
- ❑ New symptom
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Medical alert bracelet
- ❑ Medications
- ❑ Epinephrine kit

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT CIRCULATION

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the client's condition / situation as it relates to the need for functional perfusion.

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration from previous

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Pacemaker
  Rate: _____
  Date checked: _____
- ❑ Implantable defibrillator
- ❑ Thrombolytic stocking
- ❑ Activity restrictions
- ❑ Medications
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

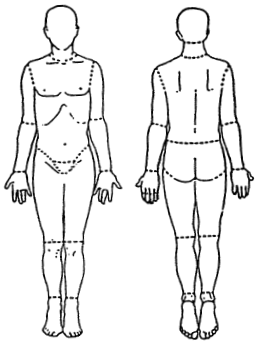
PART TWO

FOCAL ASSESSMENT COMFORT / PAIN MANAGEMENT

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL



AREA OF PAIN	TYPE OF PAIN	FREQUENCY / DURATION	CLIENT'S EMOTIONAL RESPONSE

ONSET

- ❑ Chronic
- ❑ New symptom
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Stabilize

Describe the client's situation / condition as it relates to comfort / pain management.

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Describe the client's care needs.

- ❑ Manages independently
- ❑ Assistance to setup
- ❑ Some supervision / assistance required
- ❑ Other to perform pain management, client participates

FORMAL RECOMMENATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Medications ❑ T.E.N.S
- ❑ Patient controlled narcotic
- ❑ Wax ❑ Cold ❑ Splints
- ❑ Massage
- ❑ Acupressure / acupuncture
- ❑ Therapeutic touch
- ❑ Relaxation / visualization
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT

COMMUNICATION / RECEPTIVE UNDERSTANDING

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

- ❑ Limited understanding of verbal communication
- ❑ Uses lip reading, written material or structured sign language to understand
- ❑ Able to understand only gestures, facial expressions, simple pictures or environmental cues
- ❑ Unable to understand

Describe the client's condition / situation as it relates to the need to understand others.

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration from previous

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Lipreads
- ❑ Sign language - formal
- ❑ Gestures
- ❑ Facial expressions
- ❑ Environmental cues
- ❑ Symbol board

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
- FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT COMMUNICATION / SPEECH

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

❑ Able to communicate verbally, understood with difficulty
❑ Unable to communicate verbally, uses aids to communicate
❑ Unable to communicate by any means

Describe the client's current situation / condition as it relates to the need to communicate to others.

ONSET

❑ Chronic condition
❑ New symptom
❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:
❑ Improve
❑ Deteriorate
❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

❑ Manages independently
❑ Assistance to set up
❑ Supervision / assistance required, client participates
❑ Unable to manage, needs task performed

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

❑ Sign language
❑ Writes
❑ Gestures
❑ Symbol board
❑ Speaking valve
❑ Lipreading
❑ Interpreter

SUMMARY

❑ MANAGED PROBLEM
❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
FOR _____
❑ SERVICE PROBLEM
❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT ELIMINATION BOWEL / BLADDER

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the client's current situation / condition as it relates to the need for bowel and bladder elimination.

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

- ❑ Manages independently
- ❑ Assistance to set up
- ❑ Supervision / assistance required, client participates
- ❑ Unable to manage, needs task performed

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Ostomy supplies
- ❑ Diapers
- ❑ Incontinence supplies
- ❑ Peritoneal dialysis supplies
- ❑ Opitheterization supplies
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
- FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT HEARING

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

- ❑ Hears normal speech with aids
- ❑ Hears if speech is slow, direct and in a loud voice
- ❑ Frequently misunderstands even if speech is slow, direct and in a loud voice
- ❑ Unable to hear adequately for most communication, able to hear loud voice
- ❑ Totally deaf, unable to hear loud voice

Describe the client's current situation / condition as it relates to hearing needs.

ONSET

- ❑ Chronic condition
- ❑ Acute change
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Hearing aid ❑ Rt ❑ Lt
- ❑ Lipreads
- ❑ Sign language
- ❑ Gestures

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT HOME / LIVING ARRANGEMENTS

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

- ❑ Kitchen
- ❑ Bathroom
- ❑ Laundry
- ❑ Inside structure
- ❑ Outside
- ❑ Exterior structure
- ❑ Heating
- ❑ Plumbing
- ❑ Snow removal
- ❑ Grass cutting
- ❑ Floor surfaces
- ❑ Stairs/rails
- ❑ Electrical cords
- ❑ Lighting
- ❑ Doorways
- ❑ Hallways
- ❑ Telephone
- ❑ Smoke detector
- ❑ Furnishings
- ❑ Rugs
- ❑ Living arrangements
- ❑ Pets

Describe the client's condition / situation as it relates to the need for safe housing and comfortable living arrangements.

ONSET

- ❑ Chronic condition / situation
- ❑ New condition / situation
- ❑ Deterioration of condition / situation

OUTCOMES

CONDITION / SITUATION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Ramp
- ❑ Railings
- ❑ Smoke detector
- ❑ Lifts
- ❑ Modified doorways

SUMMARY

❑ MANAGED PROBLEM
❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
FOR _____
❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT HOUSEHOLD ACTIVITIES

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

	Filling in form	Shopping	Banking	Clean house laundry	Meal preparation	Repairs yard work
INDEPENDENT						
Independent with aids / equipment						
Able to manage with assistance to setup						
Able to manage with some supervison / assistance client participates						
Unable to manage, needs constant supervision / assistance by others to perform tasks						

ONSET

- ❑ Chronic situation
- ❑ New situation
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

Describe the client's condition / situation as it relates to the need to manage household activities.

RELATED TO

❑ **REFERRAL FOR FURTHER ASSESSMENT**

FORMAL ASSESSMENT

SPECIALTY	DATE

PLANNING

Identify the client's care needs.

❑ **REFERRAL FOR RECOMMENDATIONS**

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Baskets on equipment
- ❑ Adapted calculator
- ❑ Long-handled duster
- ❑ Reaching assist
- ❑ Light-weight vacuum
- ❑ Carrying baskets
- ❑ Cart on wheels
- ❑ Riding mower
- ❑ Long-handled tools
- ❑ Meals prepared
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO **FOCAL ASSESSMENT** INFORMAL CAREGIVING

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the situation as perceived by the caregiver.

TOTAL CARE ACTIVITY

_____ / Day
Hours

_____ / Week
Days

_____ / Month
Weeks

_____ / Year
Months

_____
#Years

RELATED TO

AREA OF BURDEN	CAREGIVER NEEDS	FREQUENCY
❑ Time dependency burden		
❑ Developmental burden		
❑ Physical burden		
❑ Social burden		
❑ Emotional burden		

SUPPORT

SUPPORT PERSON	TYPE OF SUPPORT	FREQUENCY

SUMMARY

❑ MANAGED PROBLEM
❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
FOR _____
❑ SERVICE PROBLEM
❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in burden
- ❑ Changes in support

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

Initial / Date

❑ SUPPORT NEEDS MANAGED
❑ CLIENT AT RISK FOR INSTITUTIONALIZATION IF INFORMAL SUPPORT UNAVAILABLE ❑ Low ❑ High
❑ CAREGIVER AT RISK FOR _____ ❑ Low ❑ High

❑ SUPPORT NEEDS UNMET
❑ REFERRAL / CONTACT RECOMMENDED
TO _____ FOR _____

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in burden
- ❑ Changes in support

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

Initial / Date

❑ SUPPORT NEEDS MANAGED
❑ CLIENT AT RISK FOR INSTITUTIONALIZATION IF INFORMAL SUPPORT UNAVAILABLE ❑ Low ❑ High
❑ CAREGIVER AT RISK FOR _____ ❑ Low ❑ High

❑ SUPPORT NEEDS UNMET
❑ REFERRAL / CONTACT RECOMMENDED
TO _____ FOR _____

PART TWO

FOCAL ASSESSMENT LIFESTYLE / RECREATION

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the client's condition / situation as it relates the need for recreation and lifestyle maintenance.

ONSET

- ❑ Chronic condition
- ❑ Acute change
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

- ❑ Independant in leisure / recreation
- ❑ Initial assistance required
- ❑ Intermittent assistance / supervision, client participates
- ❑ Leisure / recreation stimulation provided by others

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

❑ Recreational supplies:

_____

_____

_____

_____

- ❑ T.V.
- ❑ Radio
- ❑ Stereo
- ❑ Modified equipment
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT MEDICATION MANAGEMENT

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the current situation / condition as it relates to the need for management of medications.

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration from previous

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Dosette
- ❑ Preloaded syringes
- ❑ Premixed IV
- ❑ Other _____

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT MENTAL STATUS

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

❑ ALTERED AWARENESS
- ❑ Reduced awareness, able to shift focus; sustain attention to environmental stimuli
- ❑ Fluctuating awareness, unable to consistently shift focus; sustain attention
- ❑ Consistently unresponsive

❑ ALTERED ORIENTATION

❑ Fluctuating	❑ Consistently		
❑ Orientated to	❑ Person	❑ Place	❑ Time

❑ ALTERED MEMORY

❑ IMMEDIATE	❑ Intact	❑ Impaired	❑ Significantly impaired
❑ RECENT	❑ Intact	❑ Impaired	❑ Significantly impaired
❑ REMOTE	❑ Intact	❑ Impaired	❑ Significantly impaired

❑ ALTERED AWARENESS

❑ PERCEPTIONS	❑ Occasionally	❑ Consistently	❑ Inappropriate	❑ Impaired
❑ CONCENTRATION	❑ Occasionally	❑ Consistently	❑ Inappropriate	❑ Impaired
❑ JUDGEMENTS	❑ Occasionally	❑ Consistently	❑ Inappropriate	❑ Impaired
❑ DECISION MAKING	❑ Occasionally	❑ Consistently	❑ Inappropriate	❑ Impaired

ONSET
- ❑ Chronic
- ❑ New symptom
- ❑ Deterioration

OUTCOMES
CONDITION EXPECTED TO:
- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

Further describe the clients' problem / condition / situation as it relates to the need for functional mentation.

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

- ❑ GENERAL OBSERVATION
- ❑ CLOSE OBSERVATION
- ❑ CONSTANT OBSERVATION
- ❑ INTERMITTENT INTERVENTION
  - ❑ Twice a week
  - ❑ Once a day
  - ❑ Twice a day
  - ❑ Less than hourly
  - ❑ Hourly
  - ❑ Every 15 minutes

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT
- ❑ Medication
- ❑ Restraints
- ❑ Alarm system
- ❑ Other _____

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT MOBILITY - INDOOR / OUTDOOR

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

	Indoor mobility	Outdoor mobility	Stairs / ramps	Transfers	Transportation
INDEPENDENT WITH AIDS / EQUIPMENT					
Able to manage with supervision / assistance to set up					
Able to manage with supervision / assistance, client participates					
Unable to manage, needs constant supervision / assistance of one person					
Unable to manage, needs constant supervision / assistance of two people					

ONSET

- ❑ Chronic situation
- ❑ New change in situation
- ❑ Deterioration of situation

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

Describe the client's situation / condition as it relates to the need for mobility.

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Wheel chair
  - ❑ Electric ❑ Manual
  - ❑ Adapted
- ❑ Scooter ❑ Walker
- ❑ Cane ❑ Handrails
- ❑ Bannisters ❑ Ramps
- ❑ Mechanical lifts
- ❑ Seeing eye dog
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT NUTRITION - DIET / DENTITION / EATING

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

- ❑ Overweight
- ❑ Underweight
- ❑ Dehydrated
- ❑ No teeth
- ❑ Poor condition
- ❑ Mouth lesions
- ❑ Difficulty chewing
- ❑ Difficulty swallowing
- ❑ Tendancy to choke
- ❑ Limited ability to chew
- ❑ Limited ability to swallow
- ❑ Signs of inadequate nutrition
- ❑ Weight loss
- ❑ Special diet

Describe the client's situation / condition as it relates to nutritional needs.

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration of condition

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

- ❑ Manages independently
- ❑ Assistance to setup
- ❑ Supervision / assistance required, client participates
- ❑ Other performs activity

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Dentures
  - ❑ Upper
  - ❑ Lower
- ❑ Tube feeding equipment
- ❑ Eating aids

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
- FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT PHYSICAL FUNCTION

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

- ❑ Hemiplegia
- ❑ Paraplegia
- ❑ Quadraplegia
- ❑ Fracture
- ❑ Amputation
- ❑ Limited joint R.O.M.
- ❑ Contractures
- ❑ Weakness
- ❑ Limited muscle strength
- ❑ Inactivity tolerance
- ❑ Abnormal muscle tone
- ❑ Altered pain perception
- ❑ Impaired sensation
- ❑ Impaired fine motor coordination
- ❑ Tremors
- ❑ Ataxia
- ❑ Impaired sitting balance
- ❑ Impaired standing balance

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration from previous

Describe the client's current condition / situation as it relates to the need for effective physical functioning.

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

- ❑ Manages independantly
- ❑ Assistance to set up
- ❑ Supervision / assistance required, client participates
- ❑ Unable to manage, needs activities performed

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Splints ❑ Casts
- ❑ Braces ❑ Orthotics
- ❑ Prosthetics
- ❑ Wax baths
- ❑ Gait training
- ❑ Hot/cold packs
- ❑ Exercise program
- ❑ R.O.M. exercises
- ❑ Joint protection training
- ❑ Energy conservation techniques

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
- FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
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Initial / Date

ASSESSMENT DATA

Date

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❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

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  FOR _____
- ❑ SERVICE PROBLEM
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Initial / Date

PART TWO

FOCAL ASSESSMENT PSYCHOLOGICAL STATUS

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

❑ ANXIOUS BEHAVIOUR
- ❑ Will participate in activities without support
- ❑ Requires management / supervision to participate in or complete activities
- ❑ Immobilized, unable to participate or cooperate in activities

❑ SUSPICION / PARANOIA
- ❑ Occasionally of unfamiliar persons
- ❑ Of most others including family / friends - behaviour does not disrupt routine
- ❑ Of most others, interferes with daily routine

❑ DEPRESSED BEHAVIOUR

❑ AGITATION
- ❑ In response to major changes in routine
- ❑ In response to minor changes in routine
- ❑ Without identifiable stressor

ONSET
- ❑ Chronic condition
- ❑ New symptom within last 3 months
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:
- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

Describe the client's situation / condition as it relates to the need for psychological safety.

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

❑ INTERVENTION REQUIRED
- ❑ Less than once a week
- ❑ Intense intervention - constant, ongoing, 24 hours per day.
- ____ times/day
- ____ hour/day
- ____ days/week

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT
- ❑ Homecare
- ❑ Medication
- ❑ Family counselling
- ❑ One on one counselling
- ❑ Group counselling
- ❑ Recreational program
- ❑ Community program
- ❑ Support group
- ❑ Lifeskills training
- ❑ Other

SUMMARY

❑ MANAGED PROBLEM
❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
FOR _____
❑ SERVICE PROBLEM
❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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- ❑ SERVICE PROBLEM
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Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

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- ❑ Changes in expected outcomes
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- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT RESPIRATION

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the client's condition / situation as it relates to respiratory needs.

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

- ❑ Manages independently
- ❑ Assistance to set up
- ❑ Supervision / assistance required, client participates
- ❑ Unable to manage, needs therapy performed.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Oxygen concentrator
- ❑ Ventilator supplies
- ❑ Tracheostomy supplies
- ❑ Nebulizer
- ❑ Oxymetry
- ❑ Suction supplies
- ❑ Humidifier
- ❑ Sterilizer / equipment
- ❑ Medication
- ❑ Postural percussion and drainage
- ❑ Deep breathing / coughing
- ❑ Inhalation
- ❑ Energy saving techniques
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
- FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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ASSESSMENT DATA

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- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
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Initial / Date

PART TWO

FOCAL ASSESSMENT

SAFETY / POTENTIAL FOR INJURY - OTHERS

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

❑ AGGRESSIVE BEHAVIOUR
- ❑ Exhibits hostility
- ❑ Argues
- ❑ Verbally abusive
- ❑ Physically abusive
- ❑ Vents aggression when approached / touched
- ❑ Initiates contact with others to vent aggression

❑ SEXUALITY
- ❑ Others express concern, discomfort with client's sexual expression

❑ HOARDING/RUMMAGING
- ❑ Hoards food / objects picked up in environment
- ❑ Searches others' belongings looking for food / objects

Further describe the client's behavioural condition / situation as it relates to the need for others' safety.

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:
- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

- ❑ GENERAL OBSERVATION
- ❑ CLOSE OBSERVATION
- ❑ CONSTANT OBSERVATION
- ❑ INTERMITTENT INTERVENTION
- ❑ Less than daily
- ❑ Daily
- ❑ More than twice daily, less than hourly
- ❑ Hourly
- ❑ Every 15 minutes

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Medication
- ❑ Restraints
- ❑ Alarm system
- ❑ Other _____

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM
- ❑ REFERRAL NEEDED TO _____ FOR _____ DATE SENT _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
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Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

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- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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- ❑ SERVICE PROBLEM
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Initial / Date

PART TWO

FOCAL ASSESSMENT SAFETY / POTENTIAL FOR INJURY - SELF

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

- ❑ IMPAIRED MEMORY — ❑ Immediate ❑ Recent ❑ Remote
- ❑ WANDERING — ❑ Attempts to leave ❑ Does not attempt to leave
- ❑ SUICIDAL IDEATION — ❑ Verbalizes suicidal ideas ❑ History of suicidal ideation
  - ❑ Verbalizes suicidal plans ❑ History of suicidal attempts
- ❑ INGESTION OF FOREIGN SUBSTANCES — ❑ Occasionally ❑ Frequently ❑ Daily
- ❑ SUBSTANCE ABUSE — ❑ Alcohol ❑ Narcotics ❑ Prescribed meds ❑ OTC meds ❑ Other
  - ❑ Abuse confirmed ❑ Abuse unconfirmed
  - ❑ Occasional excess ❑ Frequent excess ❑ Dependant
  - ❑ No obvious functioning impairment
  - ❑ Affecting relationships ❑ Impaired relationships
- ❑ SMOKING — ❑ Requires supervision ❑ Fire hazard due to smoking

Further comments regarding client's current condition / behaviour.

ONSET

- ❑ Chronic but stable over time
- ❑ New symptom
- ❑ Deterioration from previous

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

- ❑ GENERAL OBSERVATION
- ❑ INTERMITTENT INTERVENTION
- ❑ CLOSE OBSERVATION
  - ❑ At least twice / week
  - ❑ Once every 24 hours
  - ❑ Twice every 24 hours
  - ❑ More than 2 times a day
  - ❑ Hourly or more
  - ❑ Every 15 minutes

FORMAL RECOMMENATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Day book
- ❑ Medication
- ❑ Smoke detector
- ❑ Alarm system
- ❑ Other _____

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  - FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

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- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

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- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

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- ❑ SERVICE PROBLEM
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Initial / Date

PART TWO

FOCAL ASSESSMENT SEXUALITY

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the client's condition / situation as it relates to sexual needs.

ONSET

- ❑ Chronic
- ❑ New change
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

EQUIPMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

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- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

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Date

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- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

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Initial / Date

PART TWO

FOCAL ASSESSMENT SLEEP / REST

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

Describe the client's current condition / situation as it relates to the need for sleep and rest.

ONSET

- ❑ Chronic condition
- ❑ New symptoms
- ❑ Deterioration from previous

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Night light
- ❑ Radio
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

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- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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ASSESSMENT DATA

Date

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- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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- ❑ SERVICE PROBLEM
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Initial / Date

PART TWO

FOCAL ASSESSMENT SOCIAL INTERACTION

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

❑ Change in socialization pattern ❑ Participates socially at home ❑ Disruptive behaviour
❑ Socially isolated ❑ Socially inappropriate behaviour ❑ _____

Describe the client's situation / condition as it relates to the need for social interaction.

ONSET

❑ Chronic situation
❑ New change in situation
❑ Deterioration of situation

OUTCOMES

CONDITION EXPECTED TO:
❑ Improve
❑ Deteriorate
❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

❑ Requires persuasion / encouragement to engage in social activity
❑ Requires supervision / organized social programs

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

EQUIPMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

SUMMARY

❑ MANAGED PROBLEM
❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
FOR _____
❑ SERVICE PROBLEM
❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

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- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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Initial / Date

PART TWO

FOCAL ASSESSMENT SPIRITUALITY - VALUES / BELIEFS / PHILOSOPHY

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

❑ Experiencing struggle or conflict with own values / beliefs / spirituality
❑ Experiencing distress or disturbances with own values / beliefs / spirituality

Describe the client's comfort and clarity in their values and beliefs, as it relates to the need for spirituality.

ONSET

❑ Chronic condition
❑ New condition
❑ Deterioration of condition

OUTCOMES

CONDITION EXPECTED TO:
❑ Improve
❑ Deteriorate
❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

EQUIPMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

SUMMARY

❑ MANAGED PROBLEM
❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
FOR _____
❑ SERVICE PROBLEM
❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
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- ❑ SERVICE PROBLEM
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Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

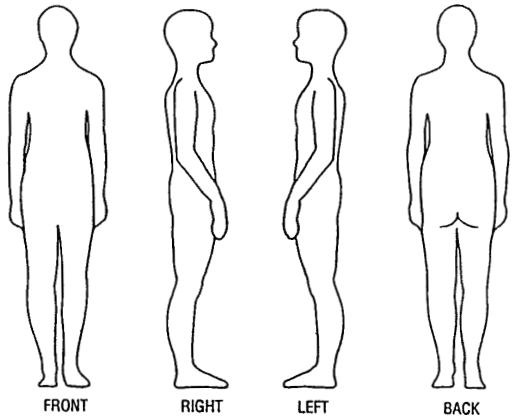
FOCAL ASSESSMENT TISSUE / SKIN INTEGRITY - HAND / FOOT CARE

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

FUNCTIONAL DESCRIPTION



CODE	SKIN INTEGRITY	TX CODE	TREATMENTS
	Dryness		1. Dressing sterile
	Rash		2. Dressing unsterile
	Edema		3. Irrigation
	Bruising		4. Hydrotherapy
X	At risk for breakdown		5. Wound packing
	Ulcer		6. Creams and lotions
△	Lesions		7. Medicated creams/ointments
	Wounds		8. Therapeutic foot care
	Incisions		9. Therapeutic hand care
	Infections		
❑	Hand care		
❑	Foot care		

ONSET

- ❑ Chronic condition
- ❑ New symptom
- ❑ Deterioration of condition

OUTCOMES

CONDITION/SITUATION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

Describe the client's situation / condition as it relates to the need for skin and tissue integrity.

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Sheepskin
- ❑ Dressing supplies
- ❑ Foot cradle
- ❑ Egg crate mattress
- ❑ Air mattress
- ❑ Hospital bed
- ❑ Other _____

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT VISION

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

- ❑ Adequate, normal vision with corrective lens
- ❑ Inadequate vision, cannot read newsprint, medications, labels
- ❑ Limited vision, cannot see obstacles / objects in environment, uses hands or cane to navigate
- ❑ Distinguishes only light/dark
- ❑ Totally blind

Describe client's current situation / condition as it relates to visual needs.

ONSET

- ❑ Chronic
- ❑ New symptom
- ❑ Deterioration

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Prescription lens
- ❑ Eye prothesis
- ❑ White cane
- ❑ Seeing eye dog
- ❑ Magnifying lens
- ❑ Braille
- ❑ Large print

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
- FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

PART TWO

FOCAL ASSESSMENT VULNERABILITY

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ASSESSMENT DETAIL

- ❑ Signs of abuse
- ❑ Signs of neglect

- ❑ Emotional
- ❑ Physical
- ❑ Sexual
- ❑ Financial

- ❑ Signs have been observed
- ❑ Signs have been expressed
- ❑ History of abuse / neglect
- ❑ Client cites a personal example

Further describe the client's situation / condition as it relates to emotional / physical / sexual / financial / safety needs.

ONSET

- ❑ Chronic situation
- ❑ New change in situation
- ❑ Deterioration of situation

OUTCOMES

CONDITION EXPECTED TO:

- ❑ Improve
- ❑ Deteriorate
- ❑ Be maintained

RELATED TO

FORMAL ASSESSMENT

SPECIALTY	DATE

❑ **REFERRAL FOR FURTHER ASSESSMENT**

PLANNING

Identify the client's care needs.

FORMAL RECOMMENDATIONS

SPECIALTY	DATE

❑ **REFERRAL FOR RECOMMENDATIONS**

MANAGEMENT

CURRENT	REQUIRED	CARE PROVIDER	FORMAL	INFORMAL	SERVICE / CARE PROVIDED	FREQUENCY

EQUIPMENT

- ❑ Safety alarm
- ❑ Telephone
- ❑ Other

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

Northwest Territories Health and Social Services

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

ASSESSMENT DATA

Date

IDENTIFY CHANGES

- ❑ Changes in condition / situation
- ❑ Changes in expected outcomes
- ❑ Changes in diagnosis dx / related to
- ❑ Changes in care needs
- ❑ Changes in current management
- ❑ Additional formal assessments
- ❑ Additional recommendations

❑ NO CHANGES
❑ PROBLEM RESOLVED

Describe changes.

SUMMARY

- ❑ MANAGED PROBLEM
- ❑ ACTIVE PROBLEM ❑ REFERRAL NEEDED TO _____ DATE SENT _____
  FOR _____
- ❑ SERVICE PROBLEM
- ❑ CLIENT AT ❑ LOW RISK ❑ HIGH RISK FOR _____

Initial / Date

	NO PROBLEM	PROBLEM	NARRATIVE NOTES	FOCAL ASSESSMENT	ASSESSMENT DATE / ASSESSMENT SIGNATURE	NO PROBLEM	PROBLEM	NARRATIVE NOTES	FOCAL ASSESSMENT	ASSESSMENT DATE / ASSESSMENT SIGNATURE	NO PROBLEM	PROBLEM	NARRATIVE NOTES	FOCAL ASSESSMENT	ASSESSMENT DATE / ASSESSMENT SIGNATURE
RESPIRATION															
SOB, colour / O_2 / activity tolerance / cough															
CIRCULATION															
chest pain / activity tolerance / edema / pulse / BP															
SKIN/TISSUE															
intactness / break down / dressings / edema / infection / lesions / bruising															
PHYSICAL FUNCTION															
muscle / joints / skeletal / balance / coordination / weakness															
MOBILITY															
indoor / indoor mobility / stairs / ramps / transfers / transportation															
ACTIVITIES OF DAILY LIVING															
eating / dressing / bathing / toileting / grooming / oral hygiene															
MEDICATION MANAGEMENT															
multiple prescribing physicans / side effects / safety / administration															
ALLERGY MANAGEMENT															
severity / allergy alerts / treatments / testing															
PAIN MANAGEMENT															
pain type / severity / tolerance / coping / pain control															
SLEEP															
sleep patterns / sleep disturbances															
HOUSEHOLD ACTIVITIES															
shopping / banking / money management / filling in form / meal preparation house cleaning / laundry / repairs / yardwork															
HOME LIVING ARRANGEMENTS															
housing / type / number of residents / safety / structure / utilities / accessibility															
MENTAL STATUS															
awareness / orientation / memory / judgement / decision making / perception															
COMMUNICATION: SPEECH															
COMMUNICATION: RECEPTIVE UNDERSTANDING															
understanding: verbal / written / gestures / lipread / environmental cues															
PSYCHOLOGICAL STATUS															
anxiety / depression / grieving suspiciousness / paranoia															

PART TWO

GENERAL ASSESSMENT

Northwest Territories Health and Social Services

CLIENT	Surname	Given Name	Health Care No.

CLIENT'S PERSPECTIVE

IDENTIFY THE CLIENT'S PERCEIVED PROBLEMS AND PERCEIVED SOLUTIONS.

DOMAIN	NO PROBLEM	PROBLEM	NARRATIVE NOTES	FOCAL ASSESSMENT	ASSESSMENT DATE / ASSESSMENT SIGNATURE	COMMENTS	NO PROBLEM	PROBLEM	NARRATIVE NOTES	FOCAL ASSESSMENT	ASSESSMENT DATE / ASSESSMENT SIGNATURE	COMMENTS	NO PROBLEM	PROBLEM	NARRATIVE NOTES	FOCAL ASSESSMENT	ASSESSMENT DATE / ASSESSMENT SIGNATURE	COMMENTS
VISION																		
HEARING																		
NUTRITION																		
diet / hydration / dentition / chewing / swallowing																		
ELIMINATION																		
bowel / bladder																		

SAFETY - SELF

wandering / memory / suicidal ideation / ingestion of foreign substances / substance abuse / smoking

SAFETY - OTHERS

agitation / aggression / hoarding / rummaging / inappropriate sexual expression

VULNERABILITY

abuse / neglect: emotional / physical / sexual / financial

SOCIAL INTERACTION

relationships / dependancy / socialization

SEXUALITY

LIFESTYLE/RECREATION

lifestyle / activities / hobbies / interests / culture

SPIRITUALITY

values / beliefs / philosophy / meaning / religion

INFORMAL CAREGIVING

PART ONE

HEALTH HISTORY

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

MEDICAL HISTORY

DIAGNOSIS	ONSET	Initial / Date	DIAGNOSIS	ONSET	Initial / Date

SURGICAL HISTORY

PROCEDURE	DATE	Initial / Date	PROCEDURE	DATE	Initial / Date

SOCIAL HISTORY

COMMENTS ON: Where client was born, places lived, family dynamics, number of siblings, marital status, number of children, education, oganizations involved in, leisure activities, pastimes, likes / dislikes, habits, spirituality, etc.

Initial / Date

Initial / Date

Initial / Date

SUPPLEMENTAL

MEDICAL / SURGICAL HISTORY

Northwest Territories Health and Social Services

MEDICAL HISTORY

DIAGNOSIS	ONSET	COMMENTS

SURGICAL HISTORY

PROCEEDURE	DATE	COMMENTS	PROCEEDURE	DATE	COMMENTS

PART ONE **MEDICATION RECORD**

Northwest Territories Health and Social Services

Client	Surname	Given Names	Health Care No.

ALLERGIES

SENSITIVITIES

PRESCRIBING PHYSICIANS

PHYSICIAN CODE	DOCTOR'S NAME	PHYSICIAN CODE	DOCTOR'S NAME	PHYSICIAN CODE	DOCTOR'S NAME
1		4		7	
2		5		8	
3		6		9	

MEDICATIONS

PHYSICIAN CODE	MEDICATION	DOSE	FREQUENCY	ROUTE	1. Self Administered 2. Assist. to set up 3. Assist. Admin. 4. Given by Other	*Start Date*	*Discontinue Date*	COMMENTS

MEDICATIONS

PHYSICIAN CODE	MEDICATION	DOSE	FREQUENCY	ROUTE	1. Self Administered 2. Assist. to set up 3. Assist. Admin. 4. Given by Other	Start Date	Discontinue Date	COMMENTS

PART TWO

Northwest Territories Health and Social Services

NARRATIVE NOTES

Client	Surname	Given Names	Health Care No.

DATE	ASSESSMENT DETAIL

PLACEMENT PLAN

Surname _____

Given Names _____

Health Care No. _____

Northwest Territories Health and Social Services

PART THREE

PLACEMENT PLAN

Northwest Territories Health and Social Services

Date (D M Y)	Client Surname	Given Names	Health Care No.

CONSENT FOR RELEASE OF INFORMATION / TREATMENT

I, _____ of _____
NAME OF CLIENT — CITY / TOWN

Authorize _____ to
NAME OF AGENCY / INSTITUTION

❑ Release the information contained in the NWT continuing care assessment and recommendation package for the purpose of sharing information with other health professionals, agencies, programs or institutions involved with the assessment and / or placement process. I am 19 years of age or older.

DATED THIS _____ OF _____ _____
DAY — MONTH — YEAR

_____ _____
CLIENT / GUARDIAN SIGNATURE — CLIENT / GUARDIAN PRINTED NAME

_____ _____
WITNESS SIGNATURE — WITNESS PRINTED NAME

_____ _____
TRANSLATOR'S SIGNATURE — TRANSLATOR'S PRINTED NAME

SERVICE SUMMARY

Formal	Informal	Service / Care Provider	Service(s) Provided	Total Hours Provided				
				Hours	Days	Weeks	Months	Years

SERVICE PLANNING

SERVICE PROBLEMS / HIGH RISK FACTORS	SERVICE RESOURCES		
	LEVEL OF SERVICE	SERVICES AVAILABLE	SERVICES REQUIRED
List ALL service problems and / or high risk factors.	❑ Residence		
	❑ Community		
	❑ Region		
	❑ Territory		

Identify any alternative ideas for servicing the client's needs.

Reviewed by: _____ Feasible ❑ Y ❑ N

Name / Title

PLACEMENT OPTIONS

Identify ALL placement options.

OPTION NO.	PLACEMENT OPTIONS	COMMENTS

PREFERRED OPTIONS

	NAME	PREFERRED CHOICE
CLIENT		
CARE PROVIDER		
GUARDIAN		
ASSESSOR		
OTHER		
OTHER		
OTHER		

CHOSEN PLACEMENT PLAN
Rational (if different from client)

Interim Plan ❑ Y ❑ N (specify)

PLACEMENT REVIEW

NAME	RELATIONSHIP	SIGNATURE	DATE

PLACEMENT IMPLEMENTATION

ACTION REQUIRED	DATE PERFORMED	OUTCOME / COMMENTS

PART TWO

SERVICE PLAN

Northwest Territories Health and Social Services

PAGE ____ of ____

CLIENT	Surname	Given Name	Health Care No.

SERVICE PLAN

CODES M= MANAGED A= ACTIVE R= RESOLVED

PROBLEM NO.	PROBLEM LIST	RISK FACTORS	HIGH	LOW	Date / Initial	STATUS	Date / Initial	STATUS	Date / Initial	STATUS	SERVICE PROBLEM

SUPPLEMENTAL

SOCIAL HISTORY

Northwest Territories Health and Social Services

ASSESSMENT DATE	SOCIAL HISTORY SUMMARIES