For Manitoba Health use only

Re-Assessment Form For Long Term Care Applicants

(To be used to update assessments of applicants on a waiting list)

Manitoba
Health, Healthy Living and Seniors

This is NCR paper - please press

APPLICANT'S NAME _____ (SURNAME) _____ (GIVEN NAMES)

M.H. REGISTRATION NO. _____

P.H.I.N. _____

DATE OF BIRTH DAY MO. YR. SEX _____

MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

M.H. USE

PRESENT LOCATION _____ (HOSPITAL, PERSONAL CARE HOME, OTHER)

Tel. No. _____

INSTRUCTIONS FOR COMPLETION:

1. Reassessment summary to be completed by the Case Co-ordinator for all reassessments.
2. In Winnipeg, please forward the entire form, all four pages to the Long Term Care Waiting List Co-ordinator. Please photocopy as necessary for your own files/records.
3. In all other Regions forward entire form to the RHA Home Care Manager or designate. Photocopy as necessary for your own files/records.

REASSESSMENT SUMMARY:

Dependency Level Changed:	Yes	☐	No	☐	If yes, new level ☐
Changes in Care Plan:	Yes	☐	No	☐	
Physician Reassessment:	Yes	☐	No	☐	
Clinical Investigation Done:	Yes	☐	No	☐	

_____ Date Completed

_____ Completed By

Send To: RHA Home Care Manager/Designate

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_____ _____
Date Completed Completed By

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MEDICAL DATA – TO BE COMPLETED BY PHYSICIAN

APPLICANT'S NAME _____ (SURNAME) _____ (GIVEN NAMES)

M.H. REGISTRATION NO. _____

P.H.I.N. _____

PLACE OF EXAMINATION _____ DATE OF EXAMINATION _____

Date of Previous Assessment:

PHYSICAL FINDINGS Indicate Changes Since Previous Assessment

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

IS THERE EVIDENCE OF PAST OR PRESENT ABNORMALITY OF:	NO	YES	IF "YES", GIVE FULL PARTICULARS
HEAD & NECK - INCLUDING FUNDI VISION, HEARING, SPEECH ETC.			
CARDIOVASCULAR SYSTEM INCL., HEART SOUNDS, MURMURS, HEART SIZE, BLOOD VESSELS, ETC.			
LUNGS			
ABDOMEN AND GENITALIA			
SKIN, LYMPH NODES, BREASTS, INCLUDING BED SORES, ETC.			
MUSCLES, BONES AND JOINTS, INCLUDING SPINE, ETC.			
NERVOUS SYSTEM			

MENTAL STATUS INCLUDING ALCOHOLISM		
IS FURTHER INVESTIGATION OF THE PATIENT'S COMPETENCE TO HANDLE OWN AFFAIRS INDICATED?	NO	YES

INVESTIGATIVE FINDINGS since last assessment

	RESULTS	DATE	PLACE RESULTS AVAILABLE
1) CHEST X-RAY Must be done within 1 year prior to placement			
2) Hgb			
3) FBS			
4) BUN			
5) ELECTROLYTES			
6) URINALYSIS			
7) ECG			
8)			

PRESENT THERAPY: (Include List of Medications, Occupational Therapy, Physiotherapy, Etc.)

DRUG SENSITIVITIES:

DIAGNOSES: (In order of Significance including any psychiatric diagnoses) Changed or New

1) **4)**

2) **5)**

3) **6)**

ARE DIAGNOSES KNOWN BY PATIENT? ☐ YES ☐ NO FAMILY? ☐ YES ☐ NO

Name and Address of Physician (Print Print)

_____ Telephone No.: _____

_____ Physician's Signature: _____

Send To: RHA Home Care Manager/Designate

CARE PLAN

APPLICANT'S NAME _____ (SURNAME) _____ (GIVEN NAMES)

M.H. REGISTRATION NO. _____

P.H.I.N. _____

DATE ASSESSED _____

LOCATION WHEN ASSESSED _____

CARE PLAN (Including Medications and Treatments) Indicate Changes From Previous Assessment Dietary, etc.

FACTORS AFFECTING SAFE CARE (e.g. Attitude, Behaviors, Use of Alcohol, Drugs, Wandering) Indicate Changes From Previous Assessement

Complete Using Criteria From Part III of the Long Term Care Application/Assessment Form.

DEPENDENCY ASSESSMENT: (X, A, B, C OR D IN EACH SECTION BELOW - TRANSFERRED FROM DEPENDENCY ASSESSMENT SUPPLEMENT)

I BATHING & DRESSING	
II ASSISTANCE WITH MEALS/FEEDING	
III AMBULATION/MOBILITY/TRANSFERS	

IV ELIMINATION	
V PROFESSIONAL INTERVENTION	
VI BEHAVIOUR MANAGEMENT/SUPERVISION	

ENTER TOTAL NUMBER OF EACH	A	B	C	D

DEPENDENCY LEVEL

PERSONAL CARE _____ (1,2,3 or 4) OR CHRONIC CARE _____

Send To: RHA Home Care Manager/Designate