Calgary Family Services

Outreach Client Assessment

Part One

Assessment Date:_____
FCSS Form (comp)_____ Refused_____
Discharge date:_____

Name: _____

Phone: _____ Birthdate: _____y /_____m /_____d

Address: _____ Postal Code: _____

Ethnicity: _____ Interpretation required? _____

Marital Status: _M ____D ____W ____CL ____S

PHN:_____ SIN: _____

Living Situation: ❒ alone ❒ with spouse/partner ❒ with family ❒ other ❒ rent ❒ own home

Home Safety Check completed: _____(date) Comments:_____

Referral Source:	Emergency Contact:
Name: _____	Name: _____
Phone: _____	Phone: _____(H) _____(W) _____(M)
Agency/Relationship: _____	Relationship: _____

Doctor: _____ Phone: _____ PCN: _____

Collateral Contacts

Name	Relationship	Phone	Comments

INCOME

Relevant Income Information:

OAS	GIS/All	SURV	CPP	DVA	ASB	IS	AISH	PP	OTHER

Presenting Problem(s): _____

_____

_____

_____

Comments/Action: _____

_____

_____

Transportation

Are there challenges in transportation?_____

Do you drive? ___ Yes ____ No If yes, are there any safety concerns? _____ Yes _____ No

If no, how do you get around? _____ Family/friends_____ Access ____ Taxi _____Public Transit _____None

Comment: _____

Over the last month have there been commitments you had or things you needed to do and were unable to do them because of lack of transportation? ____ Yes ____ No Comment: _____

HEALTH

How would you rate your current health status? ____ Poor _____ Moderate ____ Good

Health Concerns: _____

ADL's (Assistance with Daily Living)

_____ Independent _____ Some Assistance Needed _____ Dependant

Comments: _____

Do you require any aids to get around (cane wheelchair, walker, etc?) _____ Yes _____ No

If yes, what? _____

How many falls have you had in the last three months? _____

Medications

Medications - any concerns with your medication management? ____ Yes ____No Allergies_____

Comments: _____

Cognitive Functioning

_____No impairment identified _____ Some memory impairment _____ Significant memory impairment

Dementia Diagnosis? ____Yes____ No

Comments: _____

Decision Making Issues

Grief/Loss

Have you experienced a loss in the past two years? ____ Yes _____ No Comment(s): _____

_____

Social connections: Are there any cultural or language barriers that decrease connections? ____Yes _____No

Other barriers? _____

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Part Two (case management clients)

INITIAL ASSESSMENT	No Issue	Mostly Not	Minor	Major	Priority
Activities of Daily Living	0	1	2	3	4
Addictions	0	1	2	3	4
Caregiving Issues	0	1	2	3	4
Elder Abuse	0	1	2	3	4
Financial	0	1	2	3	4
Grief & Loss	0	1	2	3	4
Housing	0	1	2	3	4
Legal	0	1	2	3	4
Medical Resources	0	1	2	3	4
Mental Health	0	1	2	3	4
Physical Health	0	1	2	3	4
Relationship	0	1	2	3	4
Social Issues	0	1	2	3	4
Transportation	0	1	2	3	4

- **Elder Abuse Screening Completed** Date:_____

Are you at risk of being physically hurt by anyone? Is anyone yelling at you or calling you names? Is anyone taking your money or possession? Is your health at risk because of something that is being done to you OR because care you need is being withheld? Are you being forced to do things that make you uncomfortable?

Family/Social Supports

Relevant Life History

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Coping Skills/Strengths

Additional Risk Factors

Client Goals

Assessment Notes

Signature_____ **Date**_____