

Long-Term Care Clinical Geriatric Assessment (CGA)

PATIENT ID

WNL: Within Normal Limits
IND: Independent

ASST: Assisted
DEP: Dependent

Chief lifelong occupation: _____ Education: (yrs) _____

Cr Cl/eGFR: _____

Infection Control

MRSA _____ Pos _____ Neg _____
VRE _____ Pos _____ Neg _____

Flu shot given (d/m/y) _____
Pneumococcal vaccine given (d/m/y) _____
TB test done (d/m/y) _____
Tetanus (d/m/y) _____

Cognitive Status	Emotional	Behaviours
<input type="checkbox"/> WNL	<input type="checkbox"/> WNL	<input type="checkbox"/> ↓Mood
<input type="checkbox"/> Dementia	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Delirium	<input type="checkbox"/> Other	<input type="checkbox"/> Verbal Non-aggressive
MMSE _____	<input type="checkbox"/> Hallucinations/Delusions	<input type="checkbox"/> Verbal Aggressive
Date (d/m/y): _____		<input type="checkbox"/> Physical Non-aggressive
		<input type="checkbox"/> Physical Aggressive

Communication:			Foot-care needed	Dental care needed
Speech	Hearing	Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> WNL	<input type="checkbox"/> WNL	<input type="checkbox"/> WNL	Skin Integrity Issues	
<input type="checkbox"/> Impaired	<input type="checkbox"/> Impaired	<input type="checkbox"/> Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Strength		Upper: Proximal Distal R L		Personal Directives <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> WNL	<input type="checkbox"/> Weak	Lower: Proximal Distal R L		Substitute Decision Maker:	

Mobility	Transfers Walking Aid	<input type="checkbox"/> IND	<input type="checkbox"/> ASST	<input type="checkbox"/> DEP	Tel #: _____
		<input type="checkbox"/> IND Slow	<input type="checkbox"/> ASST	<input type="checkbox"/> DEP	

Balance	Balance Falls	<input type="checkbox"/> WNL	<input type="checkbox"/> Impaired	Code Status: <input type="checkbox"/> Do Not Attempt to Resuscitate <input type="checkbox"/> Do Not Hospitalize <input type="checkbox"/> Hospitalize <input type="checkbox"/> Attempt to Resuscitate	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	Frequency		

Elimination	Bowel Bladder	<input type="checkbox"/> Constip	<input type="checkbox"/> Cont	<input type="checkbox"/> Incont	Marital Status
		<input type="checkbox"/> Catheter	<input type="checkbox"/> Cont	<input type="checkbox"/> Incont	

Nutrition	Weight Appetite	<input type="checkbox"/> STABLE	<input type="checkbox"/> LOSS	<input type="checkbox"/> GAIN	Family Stress
		<input type="checkbox"/> WNL	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR	

ADLs	Feeding	<input type="checkbox"/> IND	<input type="checkbox"/> ASST	<input type="checkbox"/> DEP	Married <input type="checkbox"/> None <input type="checkbox"/> Divorced <input type="checkbox"/> Low <input type="checkbox"/> Widowed <input type="checkbox"/> Moderate <input type="checkbox"/> Single <input type="checkbox"/> High <input type="checkbox"/>
	Bathing	<input type="checkbox"/> IND	<input type="checkbox"/> ASST	<input type="checkbox"/> DEP	
	Dressing	<input type="checkbox"/> IND	<input type="checkbox"/> ASST	<input type="checkbox"/> DEP	
	Toileting	<input type="checkbox"/> IND	<input type="checkbox"/> ASST	<input type="checkbox"/> DEP	

1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>
5.	<input type="checkbox"/>
6.	<input type="checkbox"/>
7.	<input type="checkbox"/>
8.	<input type="checkbox"/>
9.	<input type="checkbox"/>
10.	<input type="checkbox"/>
11.	<input type="checkbox"/>
12.	<input type="checkbox"/>

Scale 5. Mildly Frail 6. Moderately Frail 7. Severely Frail 8. Very Severely ill 9. Terminally Ill

Note: Shaded areas to be completed by physician.

