Santé et Services sociaux Québec * *



MULTICLIENTELE AUTONOMY ASSESSMENT SHORT-TERM CARE CLIENTELE

Date of birth		Room no.	File no.	
Year Month	Day	riodin no.	The ne.	
First and last name at	birth			
Usual name or spous	e's name			
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A 1.1				
Address				
Postal code	Telephone Area code			Sex
	Area code		1	м 🗆 ғ 🗆
Health insurance no.		Name of	attending physic	ian

Specify, if necessary, the source of information: User - Family or Friend - Evaluator **Problem STATE OF HEALTH** 1. PERSONAL AND FAMILY HEALTH HISTORY AND CURRENT DIAGNOSES (physical and mental illness, including chronic or stabilized problems –, congenital defects, hospitalizations, surgeries, traumas) Allergies (medication, food, environment): ___ 2. PHYSICAL HEALTH Difficulties experienced or specific observations No Yes • Digestive function (pain, nausea, vomiting, diarrhea, constipation, gas, dysphagia, etc.) If so, specify: _ • Respiratory function (pain, coughing, sputum, breathing difficulties, etc.) If so, specify: __ • Cardiovascular function (pain, palpitations, pacemaker, etc.) If so, specify: __ • Genitourinary function (pain, urinary problems, genital or gynecological problems, etc.) If so, specify: _

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File no.		

Specify, if necessary, the source of information: User – Family or Friend – Evaluator		Prob	lem
2. PHYSICAL HEALTH (cont'd)			
Difficulties experienced or specific observations	No	Yes	
Motor function (pain, deformation, limited movement, strength, coordination, trembling, balance, physical endurance, etc.) If so, specify:			
Sensory function: eyes, ears, nose, mouth, touch (pain, discharge, inflammation, sensitivity, etc.) If so, specify:	- 		
Skin function (wounds, redness, swelling, discharge, etc.) If so, specify:	- 		
Other information If so, specify:			
Height: Weight: Weight gain or loss: If relevant:	T°	_	
	oblem entified	No — Yes —	— N — Y
3. PSYCHOLOGICAL HEALTH (depressed, suicidal, paranoid, delirious, violent, manic, etc.) Difficulties experienced or specific observations: No			
	oblem entified	No — Yes —	- N - Y
4. SPECIFIC CARE (care required by user: bandages, various catheter care, oxygen, aspiration of secretions, postural drainage, peritoneal dialysis, etc., and other care as requested) No			
Yes, description, frequency and by whom:			
	oblem entified	No — Yes —	— N — Y

File no.	1

Specify, if necessary, the source of information: User – Family or Friend – Evaluator

Problem

1										
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File no.		

*Indicate: Disability level: 0 = Completely autonomous -0,5 ou -1,5 = Autonomous with some difficulty -1 = Requires monitoring or stimulation -3 = Totally dependent

Handicap level: H (0, -1, -2, -3) Stability of resources: S (– Decrease, + Increase, • Stable)

Disabilities H S S 1-15 S H S S S 1-15 S S S S S S S S S										,	
1. Eating 2. Washing 3. Dressing 4. Grooming 5. Urinary function 6. Bowel function 7. Toileting Technical Aid	ADL‡						2	н	s		If user has problems or disabilities, specify:
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	Technical Aid										

File no.		

PSYCHOSOCIAL SITUATION	Problem	If user has problems or disabilities, specify:
	No Yes	
1. Social history		
2. Family situation		
3. Main caregivers		
4. Social network		
5. Community, public and private resources		
6. Affective state		
7. User's impressions		
8. Sexuality		
9. Personal, spiritual beliefs and values		
	Problem	
ECONOMIC CONDITIONS	No Yes	
Capacity to meet obligations	110	
1. Capacity to meet obligations		
DUVCICAL ENVIRONMENT	Problem	
PHYSICAL ENVIRONMENT	No Yes	
Housing conditions		
Personal and environmental safety		
3. Accessibility		
4. Proximity of services		
		Year Month Day
		Year Month Day
Signature		Year Month Day