FIREHOUSE SERVICE COORDINATION PROGRAM
SCREENING & ASSESSMENT FORM

Preliminary assessment is designed to help the service coordinator develop a service plan for the resident. The information gained through this assessment will help the service coordinator refer and link the resident to services or a network of services that meet the specific and immediate needs or situation of the resident.

Resident Contact Information

First Name:	Last Name:	M.I.
Address 1:		
Address 2:		
City:	State:	Zipcode:
Home Phone:	Cell Phone:	Other Phone:
E-mail:		

Emergency Contact Person:		
Home Phone:	Cell Phone:	Other Phone:
E-mail:		

Caregiver Contact Information (if different from Emergency Contact):		
First Name:	Last Name:	M.I.
Home Phone:	Cell Phone:	Other Phone:
E-mail:		

Screening

Use the questions below to determine the priority level for resident assessment.

Screening Date: ___________________________

Higher Priority:

☐ Resident was not transported to hospital.

☐ Resident lives alone

☐ Referred by service provider who interacted with resident, i.e. medic or city official

☐ Resident has made multiple 911 calls

☐ Resident has had multiple ER visits with no admittance in short period of time

☐ Resident is having difficulties with medical equipment, i.e., oxygen tank

Lower Priority:

☐ Resident has family or other support

☐ Resident got immediate attention for his/her medical need

☐ Referral from Quality Assurance report

☐ Services are currently in place

Resident Assessment

Assessment Date: ____________________________

Gender: ____F ____M

Date of Birth: _____/_____/_____

Ethnicity:
☐ Asian ☐ Black ☐ Hispanic ☐ Non-Hispanic, White or ☐ Other ________________

How does the resident want to be addressed?
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ First Name ☐ Nick Name ☐ Other
____

1. What are the resident's current health status and/or medical conditions?

2. What are the resident's past medical conditions?

3. Has the resident had any hospitalizations in the past 6 months? In the past year?

4. What are your observations of the resident's . . .

    a. physical state:

    b. emotional state:

    c. cognitive function:

5. Did you observe any evidence of abuse and/or neglect? If so, please describe.
   (Report per legal requirements.)

6. What kind of social support does the resident have?

- ☐ Family
- ☐ Friends
- ☐ Neighbors
- ☐ Church
- ☐ Other

Comments:

7. Does the resident have caregiver support?

   a. If a family or informal caregiver is involved, how much care is being received?

   - ☐ Daily
   - ☐ Weekly
   - ☐ Intermittent

   Comments:

   b. Does this resident provide care for someone else?

   - ☐ Spouse
   - ☐ Child
   - ☐ Other

   Comments:

8. Does the resident have any of the following documentation?

☐ Advanced Care Directives
Living Will
Do Not Resuscitate Order (DNR)
Durable Health Care Power of Attorney / Health Care Proxy
☐ Durable Financial Power of Attorney
☐ Other

Comments:

9. What services are already in place for the resident?

10. Does the resident need help with any of the following tasks?

Katz Basic Activities of Daily Living (ADL) Scale		
	Independent	
	Yes	No
1. **Bathing** (sponge bath, tub, or shower) Receives either no assistance or assistance bathing only one part of body		
2. **Dressing** – Gets clothes and dresses without any assistance except for trying shoes.		
3. **Toileting** – Goes to toilet room, uses toilet, arranges clothes, and returns without any assistance (may use cane or walker for support and may use bedpan/urinal at night		
4. **Transferring** – Moves in and out of bed and chair without assistance (may use cane or walker)		
5. **Continence** – Controls bowel and bladder completely by self (without occasional “accidents”)		
6. **Feeding** – Feeds self without assistance (except for help with cutting meat or buttering bread)		

Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. JAGS, 31(12), 721-726.

Lawton-Brody Instrumental Activities of Daily Living (IADL) Scale			
A. Ability to use Telephone		**E. Laundry**	
1. Operates Telephone on own initiative – looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
2. Dials a few well-known numbers	1	2. Launders small items – rinses stockings, etc.	1
3. Answers telephone but does not dial	1	3. All laundry must be done by others	0
4. Does not use the telephone at all	0		
B. Shopping		**F. Mode of Transportation**	
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
C. Food Preparation		**G. Responsibility for Own Medications**	
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage	0
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0		
1. Housekeeping		**H. Ability to Handle Finances**	
1. Maintains house alone or with occasional assistance (e.g. “heavy work domestic help”)	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank)	1
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money	0
4. Needs help with all home maintenance tasks	1		
5. Does not participate in any housekeeping tasks	0		

Lawton, M.P., and Brody, E.M. “Assessment of older people: Self-maintaining and instrumental activities of daily living.” Gerontologist 9:179-186, (1969).

11. According to the scoring scale provided, how did the resident perform on the Activities of Daily Living (ADL) functional assessment?

Scoring the *Katz Basic Activities of Daily Living (ADL) Scale*:

1. Residents are scored yes/no for independence in 6 functions.
   - Score of 6 “yes” answers = full function
   - Score of 4 “yes” answers = moderate impairment
   - Score of 2 or less “yes” answers = severe functional impairment
2. Independence in ADLs increases as the score approaches 6 “yes” answers.

ADL Score	Comments
☐ Fully functional ☐ Moderately impaired ☐ Severely impaired	

12. According to the scoring scales provided, how did the resident perform on the Instrumental Activities of Daily Living (IADL) functional assessment?

Scoring the *Lawton-Brody Instrumental Activities of Daily Living (IADL) Scale*:

1. Residents are scored in 8 domains of function.
2. Points are totaled in sections A-H; the score may range from 0-8.
3. The higher the score, the greater the person’s abilities.
   - Score of 8 = high function / fully independent
   - Score of 6 = moderately high function / independent
   - Score of 4 = moderately low function / dependent
   - Score of 2 or less = very low function / fully dependent

IADL Score	Comments
☐ Fully independent / high function ☐ Independent / moderately high function ☐ Dependent / moderately low function ☐ Fully dependent / Very low function	

13. Does the resident use adaptive equipment, i.e., cane, walker, wheelchair? If yes, describe:

14. What did you observe regarding the condition and safety of the resident's home?

☐ Yes ☐ No Lighting adequately bright, easy-to-reach switches, night lights

☐ Yes ☐ No Flooring in good repair, carpet tacked down, surfaces not slick or slippery, no rugs or mats

☐ Yes ☐ No Hallways and exits free of clutter

☐ Yes ☐ No Stairways and steps in good repair, handrails present

☐ Yes ☐ No Drawers and cupboards closed

☐ Yes ☐ No Cords and personal items removed from floors

☐ Yes ☐ No Refrigerator clean / Food fresh

Describe areas of concern:

15. Have any other measures been taken to safeguard the home, i.e., raised toilet seats, shower grab bars, non-skid mats, etc.

16. What did you observe regarding the resident's general home maintenance, i.e., lawn mowed, snow removed, gutters cleaned, etc.?

17. Does the resident have any of the following risk factors for falling?

☐ Yes ☐ No History of falls
☐ Yes ☐ No Uses assistive device (cane, walker)
☐ Yes ☐ No Visual or hearing deficit
☐ Yes ☐ No Needs assistance with daily activities (ADLs)
☐ Yes ☐ No Multiple medications (4 or more)
☐ Yes ☐ No Cognitive deficit (Alzheimer's disease, vascular dementia, etc.)
☐ Yes ☐ No Home safety issues

18. Does the resident speak English? ☐ Yes ☐ No

    a. What is the resident's native language? ______________ Country of birth? _______________

    b. Does the resident require translation services? ☐ Yes ☐ No

19. Does the resident have culturally sensitive health and/or illness beliefs and practices regarding health or social services? For example, does the resident engage in different types of healing practices, i.e., hot tea and lemon for cold, copper bracelet for arthritis, magnets, etc.?

20. How important are spirituality and religious beliefs for the resident?

    ☐ Do the resident's spiritual or religious beliefs influence how he/she takes care of him/herself?

    ☐ How does the resident want to address his/her spiritual or religious beliefs regarding service referral?

    Describe:

21. Primary Care Doctor:

Doctor's Name:		
Company:		
Address 1:		
Address 2:		
City:	State:	Zipcode:
Phone:	Fax:	

22. Health insurance coverage:

    ☐ Primary Health Coverage ____
    ☐ Medicare ____
    ☐ Medicaid ____
    ☐ Other ____

23. Does the resident need financial assistance to pay for health care or social services?
☐ Yes ☐ No

24. Is the resident ready for change (choose one)?

☐ Does not want to change behavior in the foreseeable future (precontemplation)

☐ Is thinking about changing but has not made a commitment to take action yet (contemplation)

☐ Plans on taking action in the next month and/or near future (preparation)

☐ Is currently modifying his/her behavior, experiences, and/or environment to overcome problems (action)

☐ Is working to prevent relapse and maintain improved status (maintenance)

25. Current Situation / Service Plan:

a. Immediate needs:

b. Future needs:

c. Follow-Up Timeframe:

☐ Weekly: _____/_____/_____
☐ Bi-weekly: _____/_____/_____
☐ Monthly: _____/_____/_____
☐ Bi-Monthly: _____/_____/_____
☐ Quarterly: _____/_____/_____
☐ Bi-Yearly: _____/_____/_____
☐ Yearly: _____/_____/_____
☐ Other: _____/_____/_____