Newfoundland Labrador

Long Term Care and Community Support Program
Adult Needs Reassessment

This form is completed annually and only when there is minimal or no change in a client's condition and services are still required.

Record appropriate changes in function since last assessment and effects of these changes on level of independence.

Name: _____ RHA File #: _____

Address: _____ CRMS File #: _____

_____ MCP #: _____

Postal Code: _____ Date Reassessment completed: _____

Telephone #: _____

EMERGENCY CONTACT
(Record only if contact information has changed)

Name: _____

Address: _____

_____

Postal Code: _____

Telephone #: Residence: _____

Business: _____

Relationship: _____

FAMILY CONTACT
(Record only if contact information has changed)

Name: _____

Address: _____

_____

Postal Code: _____

Telephone #: Residence: _____

Business: _____

Relationship: _____

What recent event(s) precipitated this Reassessment? _____

_____

_____

_____

_____

_____

_____

_____

_____

Assessor's Signature: _____ Profession: _____

Telephone Number: _____ Date: _____

File #: _____

PHYSICAL ACTIVITIES OF DAILY LIVING

Physical Activities of Daily Living		Ind	Min	Mod	Dep	TD	N/A	COMMENTS (Refer to specific ADL when commenting, ie. ambulation)
Grooming (ie., facial wash, mouth care, combing hair, etc.)								
Shaving								
Hair Care (Shampoo, style, etc.)								
Skin Care								
Hand Care	Wash Hands							
	Trim Nails							
Foot Care	Care for Feet							
	Trim Nails							
Bathing	Tub/Shower							
	Sponge							
	Bed							
Dressing	Upper Extremities							
	Lower Extremities							
Eating								
Toileting								
Ambulation								
Transfer								
Turning/Positioning								

(Ind) Independent — needs no assistance, may use special devices
(Min) Minimal Assistance/Cueing — needs reminding or occasional supervision/assistance
(Mod) Moderate Assistance/Supervision — needs intermittent supervision or assistance to complete some tasks, may use special devices
(Dep) Dependent/Constant Supervision — needs constant critical watching to give direction or complete task or someone else to perform function
(TD) Technology Dependent — needs a medical device to compensate for loss of a vital body function and ongoing professional care, e.g. ventilator, etc.
(N/A) Not Applicable — does not apply

Assessor: _____ Profession: _____ Telephone #: _____ Date: _____

File #: _____

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Instrumental Activities of Daily Living		Ind	Min	Mod	Dep	N/A	COMMENTS (Refer to specific IADL when commenting, ie. shopping)
Meal Preparation							
Home Management	Laundry						
	Bathroom/Kitchen						
	Bedmaking/Dusting						
	Light Vacuuming						
	Other						
Ability to use Telephone							
Personal Financial Affairs							
Medication							
Transportation							
Shopping							
Yard Work							
Snow Removal							

(Ind) Independent — needs no assistance, may use special devices
(Min) Minimal Assistance/Cueing — needs reminding or occasional supervision/assistance
(Mod) Moderate Assistance/Supervision — needs intermittent supervision or assistance to complete some tasks, may use special devices
(Dep) Dependent/Constant Supervision — needs constant critical watching to give direction or complete task or someone else to perform function
(N/A) Not Applicable — does not apply

Assessor: _____ Profession: _____ Telephone #: _____ Date: _____

File #: _____

SUMMARY AND RECOMMENDATIONS

Descriptors to Consider

- orientation/cognition
- physical assessment
- physical activities of daily living
- instrumental activities of daily living
- behavioral assessment
- mental health assessment
- social assessment
- environmental assessment
- personal hobbies/interests
- equipment (to accompany, or required)
- changes in life circumstances
- perception of needs
- client's strengths
- client's limitations
- current conflict/stress
- other family/caregiver dynamics

SUMMARY

CURRENT SERVICES

RECOMMENDATIONS

Assessor's Signature:_____ Profession:_____

Telephone Number:_____ Date:_____