Alzheimer's QUEENSLAND

COMPREHENSIVE MEDICAL ASSESSMENT

Resident Name:	Date of Birth:

PART 1 – RESIDENT DETAILS ☐ *(tick when complete)*

☐ New resident	☐ Existing resident

If existing resident – what is the reason for CMA?

Next of kin / guardian details:

Name:	Relationship:
Phone Number:	Email:

Enduring Medical Power of Attorney:

☐ As above *(if different, please complete details below)*

Name:	Phone Number:

Email:

Does the resident have a current Advance Care Directive in place? ☐ Yes ☐ No

Has the resident had a previous CMA? ☐ Yes ☐ No

(if yes, include date of last CMA – date/service provided by below)

Resident consent:

☐ Explanation of CMA given	☐ Consent for a CMA obtained
☐ Consent for a CMA not obtained	☐ Consent given by Resident
☐ Consent given by Representative	☐ Not applicable

Date consent was given:

CMA service details provided by: *(Residents usual doctor? Include date of service, report to usual Dr)*

PART 2 – DETAILED MEDICAL HISTORY ☐ *(tick when complete)*
Results of relevant previous assessments *(e.g., GPs, specialists and/or community-based assessments)*
Results of relevant previous investigations and allied health interventions
Results of assessment and intervention by nursing staff of the RACF
Details of allergies and drug intolerance:

Resident's current medications: *(include prescribed/non-prescribed medication. Include Medication Profile)*	
Acute and chronic pain: *(please specify)*	
Has the resident had any falls in the last three months? ☐ Yes ☐ No *(if yes, specify below)*	
Immunisation status:	
☐ Influenza immunisation is current	☐ Influenza immunisation is not current
☐ Tetanus immunisation is current	☐ Tetanus immunisation is not current
☐ Pneumococcus immunisation is current	☐ Pneumococcus immunisation is not current
☐ Not applicable	
Continence:	
☐ Urinary continence is normal	☐ Urinary continence is abnormal
☐ Urine test (as indicated) is normal	☐ Urine test (as indicated) is abnormal
☐ Faecal continence is normal	☐ Faecal continence is abnormal

Continence – identified issues: *(please specify)*
Factors leading to admission into the RACF:
PART 3 – COMPREHENSIVE MEDICAL EXAMINATION ☐ (tick when complete)
Cardiovascular system: *(include: normal/abnormal, identified issues)*
Respiratory system: *(include: normal/abnormal, identified issues)*
Pain: *(include: acute/chronic, cause of pain if present)*

Physical function: *(include ADLs, identified issues)*
Psychological function:

☐ The resident's mood is normal	☐ The resident's mood is depressed
☐ The resident's cognition is normal	☐ The resident's cognition is impaired
☐ Test/screening tool used (e.g., MMSE)	

Psychological function: *(if issues identified above, please specify below)*
Oral health: *(include teeth/dentures/gums and any identified issues)*
Nutritional status: *(include weight/height/BMI and any identified issues)*

Dietary needs: (include identified issues)
Skin integrity: (include: normal/abnormal (sores/lesions) other, and any identified issues)
Other medical examinations (as relevant): *(this may include: hearing/vision/foot care/alcohol use/sleep/smoking/cardiovascular risk factors/fitness to drive.*
Diagnosis/health status:
Immediate action:

☐ Immediate action is required for cardiovascular system	☐ Immediate action is required for respiratory system

☐ Immediate action is required for pain	☐ Immediate action is required for physical function
☐ Immediate action is required for psychological function	☐ Immediate action is required for oral health
☐ Immediate action is required for nutritional status	☐ Immediate action is required for dietary needs
☐ Immediate action is required for skin integrity	☐ Immediate action is required for continence
Other services required:	
☐ Chronic Disease Management (CDM) Care Plan required	☐ Chronic Disease Management (CDM) Care Plan not required
☐ Case Conference required	☐ Case Conference not required
☐ Medication Management Review required	☐ Medication Management Review not required
☐ Other	

Name of person completing assessment:	
Role:	
Date completed:	Time completed:
Date Uploaded to Clinical Manager:	