Comprehensive Geriatric Assessment

PATIENT DETAILS	
Name: DOB: Age: F M Hospital n: NHS n:	Geriatrician Consultant: _____ Surgical Consultant: _____ Admission Date: _____ / _____ / _____ Assessment Date: _____ / _____ / _____

HISTORY OF PRESENTATION

Name:	DOB:	Hospital No:	NHS No:

PAST MEDICAL HISTORY	SURGICAL HISTORY

MEDICATIONS					
Name	Dose	Freq.	Name	Dose	Freq.
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		
☐Dosette box					
ALLERGIES AND INTOLERANCES					

Name:	DOB:	Hospital No:	NHS No:

SOCIAL HISTORY					
Occupation:					
☐Lives alone	☐Lives with family	☐ Sheltered Accommodation	☐ Existing Package of Care OD BD TDS QDS X1 X2	☐Residential Home	☐Nursing Home
Accommodation type:	☐Home	☐Flat	☐Bungalow		
Ability to manage stairs:	☐Y	☐N	☐Stair lift		

SMOKING AND ALCOHOL HISTORY		
☐Current smoker	☐Ex-smoker	☐Non smoker
Details:		
☐Alcohol intake: _____ units/week		

MOBILITY / FUNCTIONAL STATUS					
☐Independent	☐Mobile with stick	☐Mobile with frame	☐Mobility Scooter	☐Bed to chair only	☐Bedbound

NUTRITIONAL STATUS		
Weight: _____ Kg	Height: _____ cm	BMI: _____
History of recent weight loss? ☐**Y** ☐**N**		
Details: (How much for how long)		
MUST Score:		
Modified diet (eg. Thickened, pureed, coeliac)? ☐**Y** ☐**N**		
Details:		

SKIN STATUS
Braden Scale: ____ / 23
Comments / description of pressure areas:

CONTINENCE STATUS		
Bowels: ☐Continent ☐Incontinent	Bladder: ☐Continent ☐Incontinent	
☐Urinary frequency (voids ≥ 7 times daily)	☐ Urinary urgency	
☐Nocturia (voids ≥ 2 times / night)	☐Voiding difficulty (hesitancy, straining)	
☐Urinary Tract Infections in last 3 months	☐History of constipation	
☐Short term catheter in situ	☐Long term catheter in situ	Date of insertion: ___ / ___ / ___
Indication:		

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MENTAL HEALTH STATUS		
Previous diagnosis of dementia?	☐ **Y**	☐ **N**
Forgetful over last 12 months?	☐ **Y**	☐ **N**
History of depression?	☐ **Y**	☐ **N**
Risk of delirium?	☐ **Y**	☐ **N**
On admission:		
CAM	☐ **+**	☐ **-**
AMTS	___ / 10	

VISUAL ASSESSMENT	HEARING ASSESSMENT
☐ No impaired	☐ No impaired
☐ Impaired	☐ Impaired
Comments:_____	Comments: _____

FALLS RISK / BONE HEALTH ASSESSMENT

History of falls in the last year? ☐ **Y** ☐ **N** How many? _____
History of previous fractures at any time? ☐ **Y** ☐ **N**

Details: _____

_____

Fear of falling? ☐ **Y** ☐ **N**
Previous diagnosis of osteoporosis? ☐ **Y** ☐ **N**

If **YES**: details of treatment (starting date and duration): _____

_____

If **NO**: **FRAX Score**
10 year probability of: (1) Major osteoporotic fracture: _____ (2) Hip fracture: _____

RESUSCITATION STATUS	
☐ For resuscitation	☐ Advanced Care Plan
☐ DNR in community	☐ In place
☐ DNR made on admission	☐ For discussion
☐ Not discussed	☐ N/A

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EXAMINATION

Observations:

Temperature: _____ °C

Heart rate: _____ bpm

Respiratory rate: _____ bpm

Saturations: _____ %

Pain: _____ / 10

Lying / sitting BP: _____ / _____ mmHg HR: ____

Standing BP (at 0'): _____ / _____ mmHg HR: ____

Standing BP (at 3'): _____ / _____ mmHg HR: ____

E ___ V___ M___ GCS: _____ / 15

Capillary Blood glucose: _____ mmol/L

ECG:

Chest x-ray:

Name:	DOB:	Hospital No:	NHS No:

PROBLEMS / DIAGNOSIS	INITIAL MANAGEMENT / OPTIMISATION PLAN

Name:	DOB:	Hospital No:	NHS No:

SUMMARY / FOLLOW UP'S / COMMUNICATION WITH GP (TO BE WRITTEN ON EDN)

Name (Print):	Sign: