

Comprehensive Geriatric Assessment

Clinical Frailty Score (Rockwood Scale): _____

Patient Contact

- Home
- Care Home
- GP
- OPD
- ED Frailty

Patient's Details

Title: _____

Name: _____

Date of Birth: _____

NHS Number: _____

Patient's Address: _____

GP Practice: _____

Cognition

- Within Normal Limits
- Mild Cognitive Impairment
- Dementia
- Delirium
- Abbreviated Mental test (AMT) Score: _____
- Mental Capacity Assessment Required

Main Lifelong Occupation:

Emotional

- Within Normal Limits
- Decreased Mood
- Depression
- Anxiety
- FAtigue
- Hallucination
- Delusion
- Other: _____

<p>Motivation</p> <p><input type="checkbox"/> High</p> <p><input type="checkbox"/> Usual</p> <p><input type="checkbox"/> Low</p>	<p>Health Attitude</p> <p><input type="checkbox"/> Excellent</p> <p><input type="checkbox"/> Good</p> <p><input type="checkbox"/> Fair</p> <p><input type="checkbox"/> Poor</p> <p><input type="checkbox"/> Couldn't Say</p>
<p>Communication</p> <ul style="list-style-type: none">• Speech <p><input type="checkbox"/> Within Normal Limits</p> <p><input type="checkbox"/> Impaired</p> <ul style="list-style-type: none">• Hearing <p><input type="checkbox"/> Within Normal Limits</p> <p><input type="checkbox"/> Impaired</p> <ul style="list-style-type: none">• Vision <p><input type="checkbox"/> Within Normal Limits</p> <p><input type="checkbox"/> Impaired</p> <ul style="list-style-type: none">• Understanding <p><input type="checkbox"/> Within Normal Limits</p> <p><input type="checkbox"/> Impaired</p>	<p>Strength</p> <p><input type="checkbox"/> Within Normal Limits</p> <p><input type="checkbox"/> Weak</p> <ul style="list-style-type: none">• Upper <p><input type="checkbox"/> Proximal</p> <p><input type="checkbox"/> Distal</p> <ul style="list-style-type: none">• Distal <p><input type="checkbox"/> Proximal</p> <p><input type="checkbox"/> Distal</p>
<p>Exercise</p> <p><input type="checkbox"/> Frequent</p> <p><input type="checkbox"/> Occasional</p> <p><input type="checkbox"/> Not</p>	

Baseline (Two Weeks Ago)	Current (Today)
<p>Balance</p> <ul style="list-style-type: none"> • Balance <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired • Falls <input type="checkbox"/> Falls, Number: _____ 	<p>Balance</p> <ul style="list-style-type: none"> • Balance <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired • Falls <input type="checkbox"/> Falls, Number: _____
<p>Mobility</p> <ul style="list-style-type: none"> • Walk Inside <input type="checkbox"/> Independent <input type="checkbox"/> Slow <input type="checkbox"/> Assisted <input type="checkbox"/> Can't • Walk Outside <input type="checkbox"/> Independent <input type="checkbox"/> Slow <input type="checkbox"/> Assisted <input type="checkbox"/> Can't • Transfers <input type="checkbox"/> Independent <input type="checkbox"/> Standby <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent • Bed (In/Out) <input type="checkbox"/> Independent <input type="checkbox"/> Pull <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent 	<p>Mobility</p> <ul style="list-style-type: none"> • Walk Inside <input type="checkbox"/> Independent <input type="checkbox"/> Slow <input type="checkbox"/> Assisted <input type="checkbox"/> Can't • Walk Outside <input type="checkbox"/> Independent <input type="checkbox"/> Slow <input type="checkbox"/> Assisted <input type="checkbox"/> Can't • Transfers <input type="checkbox"/> Independent <input type="checkbox"/> Standby <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent • Bed (In/Out) <input type="checkbox"/> Independent <input type="checkbox"/> Pull <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent

<ul style="list-style-type: none">• Aid Use <input type="checkbox"/> None <input type="checkbox"/> Stick <input type="checkbox"/> Frame <input type="checkbox"/> Chair	<ul style="list-style-type: none">• Aid Use <input type="checkbox"/> None <input type="checkbox"/> Stick <input type="checkbox"/> Frame <input type="checkbox"/> Chair
Nutrition Weight <input type="checkbox"/> Normal <input type="checkbox"/> Under <input type="checkbox"/> Over <input type="checkbox"/> Obese Appetite <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Fair <input type="checkbox"/> Poor Swallow <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired Fluids <input type="checkbox"/> Impaired Solids	Nutrition Weight <input type="checkbox"/> Normal <input type="checkbox"/> Under <input type="checkbox"/> Over <input type="checkbox"/> Obese Appetite <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Fair <input type="checkbox"/> Poor Swallow <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Impaired Fluids <input type="checkbox"/> Impaired Solids
Elimination <ul style="list-style-type: none">• Bowel <input type="checkbox"/> Continent <input type="checkbox"/> Constipated <input type="checkbox"/> Incontinent <ul style="list-style-type: none">• Bladder <input type="checkbox"/> Continent <input type="checkbox"/> Catheter <input type="checkbox"/> Incontinent	Elimination <ul style="list-style-type: none">• Bowel <input type="checkbox"/> Continent <input type="checkbox"/> Constipated <input type="checkbox"/> Incontinent <ul style="list-style-type: none">• Bladder <input type="checkbox"/> Continent <input type="checkbox"/> Catheter <input type="checkbox"/> Incontinent

ADLs**• Feeding**

- Independent
- Assisted
- Dependent

• Bathing

- Independent
- Assisted
- Dependent

• Dressing

- Independent
- Assisted
- Dependent

• Toileting

- Independent
- Assisted
- Dependent

ADLs**• Feeding**

- Independent
- Assisted
- Dependent

• Bathing

- Independent
- Assisted
- Dependent

• Dressing

- Independent
- Assisted
- Dependent

• Toileting

- Independent
- Assisted
- Dependent

IADLs**• Cooking**

- Independent
- Assisted
- Dependent

• Cleaning

- Independent
- Assisted
- Dependent

• Shopping

- Independent

IADLs**• Cooking**

- Independent
- Assisted
- Dependent

• Cleaning

- Independent
- Assisted
- Dependent

• Shopping

- Independent

- Assisted
- Dependent
- **Medications**
- Independent
- Assisted
- Dependent

- **Driving**
- Independent
- Assisted
- Dependent

- **Banking**
- Independent
- Assisted
- Dependent

- Assisted
- Dependent
- **Medications**
- Independent
- Assisted
- Dependent

- **Driving**
- Independent
- Assisted
- Dependent

- **Banking**
- Independent
- Assisted
- Dependent

Sleep

- Disrupted
- Daytime Drowsiness

Socially Engaged

- Frequent
- Occasional
- Not

Social

- **Marital Status**
- Married
- Divorced
- Widowed
- Single

- **Lives**

- Alone
- Spouse
- Other

- **Home**

- House, Number of Levels: _____
- Steps, Number of Steps: _____
- Apartment
- Supported Living
- Care Home
- Other

- **Supports**

- Informal
- Other
- Requires More Support
- None

- **Caregiver Relationship**

- Spouse
- Sibling
- Offspring
- Other

- **Caregiver Stress**

- None
- Low
- Moderate
- High

- **Caregiver Occupation:** _____

Advance Directive in Place:

- Yes
- No

CPR Decision:

- Allow a natural death
- Resuscitate

Assessor: (Name, Grade & Signature):

Date: _____

Initial Comprehensive Geriatric Assessment Form

Associated Medication *(Mark meds started in hospital with an asterisk) - Consider STOPP / START

Medication	Dose	Date Commenced

	Problem List	Action Required	Action By
1			
2			
3			
5			
6			

7			
8			
9			
10			

Long Term Conditions	
1.	
2.	
3.	
4.	
5.	

Notes

- For MDT discussion, consider long CGA
- Long CGA not required, copy of Clinical Frailty score to GP

Outpatient Appointments

Department	Date and Time

Assessor: (Name, Grade & Signature):

Date: _____