Hamilton

Residential Care Facility
APPENDIX 'B' – ASSESSMENT FORM

Client Information

LAST Name:	**FIRST Name:**
Date of Birth: DD / MM / YYYY	
Address:	
Phone Number:	
Preferred language for communication: ☐ English ☐ French ☐ Other:	
Do they require an interpreter for English: ☐ Yes ☐ No	

Medical Information

Personal Physician:	
Phone Number:	
Allergies:	
Brief medical history:	
Diagnoses:	
Medications currently prescribed:	
Significant recent mental or physical changes/ incidents/ hospitalizations:	
Requires additional care?	☐ Yes ☐ No If yes, please describe:
Client able to self-medicate?	☐ Yes ☐ No

TB Skin Test (must be completed within 14 days of admission)

Testing Date	1.	2.
Results	1.	2.
If TB test was positive, result of chest x-ray and doctor assessment:		
Date of chest x-ray:		

Please complete the following with respect to this client:	
Does the client wander?	☐ Yes* ☐ No
Is the client fully ambulatory or is the client independently ambulatory with aids?	☐ Yes ☐ No*
Is the client able to independently able to maintain incontinence with minimal assistance?	☐ Yes ☐ No*
Is the client able to eat independently?	☐ Yes ☐ No*
Is the client able to maintain personal hygiene, if provided periodic assistance with care?	☐ Yes ☐ No*
Is the client able to dress independently?	☐ Yes ☐ No*
Does the client currently experience episodes of aggression?	☐ Yes* ☐ No
Responses noted with * indicate that the client is not appropriate for admission into an RCF.	

Referral Source	
Name of Physician/Health Care Professional:	
Signature:	
Date:	DD / MM / YYYY

RCF Operator:

If the health care provider, who completed this form, selected any options above that indicate the client is inappropriate for placement in a Residential Care Facility, you are not authorized to admit the client to your facility.