Wiisokotaatiwin Program Assessment Form

Patients name:	D.O.B:	Health Card#:

Primary Diagnosis if known:_____ **Date of Diagnosis:**_____

Individual aware of Diagnosis: ☐ Yes ☐ No **Prognosis:** ☐ Yes ☐ No **Does Not wish to know**: ☐ Yes ☐ No

Family aware of diagnosis: Yes ☐ No ☐ **Prognosis:** ☐ Yes ☐ No **Does Not wish to know**: ☐ Yes ☐ No

Anticipated Prognosis: ☐ < 1 month ☐ <3 months ☐ <6 months ☐ <12 months ☐ uncertain
Prognosis determined by: (Physician name and phone number)_____

Resuscitation Status: Do Not Resuscitate order on chart ☐ Yes ☐ No ☐ status unknown
Discussed with: Individual ☐ Yes ☐ No Family ☐ Yes ☐ No

Please list all service providers currently involved:

Name:	Contact Info:	Frequency
Doctor:		
CCAC:		
Nursing:		
Other:		

List all Family/informal caregiver:

Name:	Relationship:	Contact info:	Type of support:

Is there a legal power of Attorney: Finances ☐ Yes ☐ No List Name and Contact info if yes:_____
Is there a legal power of Attorney: Personal Care ☐ Yes ☐ No List Name and Contact info if yes:_____

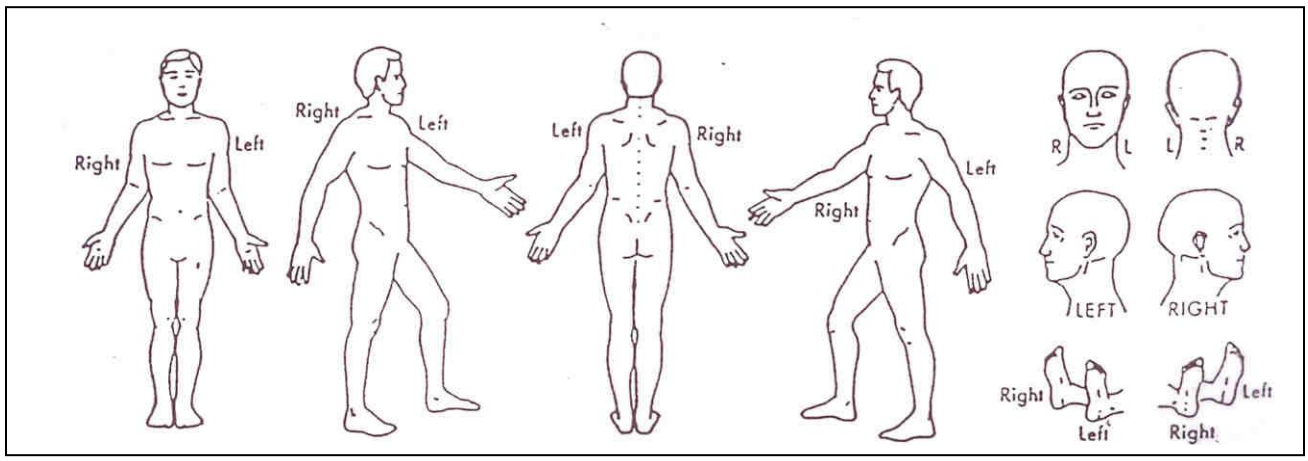
Physical Assessment:

(1) **Level of Consciousness** (alert, drowsy, stupor, unconscious) _____

Orientation: time □, place □, person □

(2) **Pain**

Location of Pain: mark on diagram



Level of Intensity (1 to 10): at present_____

After medication_____

Acceptable functional level _____

Quality of Pain (dull, sharp, burning, aching, etc.):_____

What Increases Pain (movement, eating, etc.): _____

What Relieves Pain (medication, change of position, etc): _____

Effects of Pain: nausea _____

sleep _____

appetite _____

physical activity _____

relationship with others (irritability) _____

emotions (anger, helplessness, crying) _____

concentration _____

Comments re. Pain: _____

_____

(3) **Gastrointestinal**

Diet: Regular □, Soft □, Liquid □

Supplements: _____, flavour preferred: _____

Tube feeding: _____, Loss of appetite: _____

Personal likes and dislikes: _____

Body type: Average □, Obese □, Overweight □, Cachectic □

Recent weight gain or loss: _____

Sores in mouth/throat: _____

Difficulty swallowing/chewing: _____

Nausea:
Contributing factors (i.e. food, smells, meds): _____

Medications used: _____

Vomiting: _____

Current Management: _____

Bowels:
Constipation □, Laxative/Supp used: _____

Diarrhea □, Med used: _____

Colostomy □

Incontinent □

Bladder:
Frequency □ Burning □ Nocturia □

Incontinence □ Catheter □

Comments: _____

_____

_____

(4.) Skin

Rash ☐ Dryness ☐ Itching ☐ Ascites ☐

Open areas ☐ Bruises ☐ Edema ☐

Comments: _____

_____

(5.) Respiration

SOB ☐ Wheezy ☐ Cough ☐ - production ☐

Dyspnea ☐ Smoker ☐ Uses 0_2 ☐

Comments: _____

_____

(6.) Sleep/Rest

Fatigue ☐ Insomnia ☐ Sleeping aids (i.e. Rx, milk) _____

Comments: _____

_____

Psychosocial

Reaction to Diagnosis: Anger ☐ Denial ☐

Anxiety ☐ Depression ☐ Frightened ☐

Comments: _____

_____

Problems created by Illness: (family, finances, lifestyle, employment)

_____
_____
_____
_____
_____

Where would you like to be cared for? (Home, Hospital, Other)

_____
_____
_____
_____
_____
_____

Can your Family help in the support of your care? List family member who can provide care If Required:

Assist with administering medications: □ Yes □ No □ N/A If Yes list family member(s):_____

Meal Preparation: □ Yes □ No □ N/A If Yes list family member(s):_____

Bathing and skin care: □ Yes □ No □ N/A If Yes list family member(s):_____

Toileting: □ Yes □ No □ N/A If Yes list family member(s):_____

Transferring: □ Yes □ No □ N/A If Yes list family member(s):_____

Safety Check: □ Yes □ No □ N/A If Yes list family member(s):_____

Respite and alternate care providers: □ Yes □ No □ N/A If Yes list family member(s):_____

Other: □ Yes □ No □ N/A If Yes list family member(s):_____

Training required for family: □ Yes □ No (if yes see narrative notes and care plan)

Religion:

Religious Affiliation:_____ Clergy Name:_____ Contact #:_____

Would you like a clergy visit? If Yes when?_____

Traditional Care: What Traditional Services are you receiving or would like to receive?

Smudging_____ Traditional Healer_____ Traditional Meds_____

Other:_____
_____
_____
_____

Special Care Requests:
_____
_____
_____

Does Client Meet Criteria For Wiisokotaatiwin Program:

1. PPS score of 60% or lower □ Yes □ No
2. Client has illness from which no recovery is expected and it would not be surprising if they passed within one year □ Yes □ No
3. Client could benefit from the services of the program □ Yes □ No
4. Client wished to be part of the program □ Yes □ No

Client admitted to Wiisokotaatiwin Program: □ Yes □ No
EDITH protocol initiated: □ Yes □ No If No explain why:_____

Client or POA signature:_____