



SENIORS ASSESSMENT TOOL

This Assessment Tool pertains to the Guideline:
Frailty in Older Adults – Early Identification and Management
www.BCGuidelines.ca



NAME OF SENIOR	PERSONAL HEALTH NUMBER	DATE
NAME OF PHARMACY		LOCATION

1. How has your health been since your last visit? better same worse: _____

2. Do you have concerns or problems with any of the following:

Medications No Yes: _____

Pain No Yes: _____

Falls No Yes: _____

Decreased energy No Yes: _____

Nutrition No Yes: _____

Memory No Yes: _____

Bladder/Bowels No Yes: _____

Hearing No Yes: _____

Vision No Yes: _____

Sleep No Yes: _____

Depression/Lonliness No Yes: _____

Looking after yourself No Yes: _____

Looking after your home No Yes: _____

Finances No Yes: _____

Transport No Yes: _____

3. Where do you live? own home with family facility
 other: _____

4. Do you live alone? No Yes

5. Do you have help in the home? No Yes:

6. Do you have a contact for emergencies? No Yes

If yes, who could you call? family friend neighbour Lifeline
 other: _____

7. Have you signed a Power of Attorney? No Yes

8. Have you made a Will? No Yes

9. Do you want to discuss end-of-life plans? No Yes

10. Have you signed a "No CPR" form? No Yes

11. Would you consider Lifeline quick response? No Yes I have Lifeline (or similar service)