Iowa Veterans Home
1301 Summit Street
Marshalltown, Iowa 50158

PERSONAL FUNCTIONAL ASSESSMENT

ALL INFORMATION REQUESTED ON THIS FORM IS REQUIRED except for sections titled other considerations and please comment.

IF YOUR ARE CURRENTLY IN A FACILITY, PLEASE HAVE LICENSED CAREGIVER COMPLETE THIS FORM. IF CURRENTLY IN A LONG-TERM CARE FACILITY, ATTACH COPY OF CURRENT MDS; MAR w/ PRNs; PASRR AND FACESHEET.

For each area of your functioning listed on the following pages, please mark the description which best describes your current ability. The word "assistance" means supervision, direction or personal assistance. For "Other Considerations", please note any additional information which you believe is pertinent and will assist the Admissions Committee in determining the correct level of care. Unless otherwise directed, mark the one box that is most representative of your abilities. Attach additional sheets as necessary.

Name:_____ Date: _____

Currently Living At:_____

Address:_____

_____

Telephone Number(s):_____

Name of Person Completing This Form: _____

Relationship to Applicant:_____

BATHING

☐ No assistance needed. I get in and out of shower and/or tub by myself (if tub is the usual means of bathing).

☐ Cueing only. Can bathe self

Assistance with set-up. Please explain set up required.

☐ _____

_____

Some assistance in bathing. *Please explain assistance required.*

☐ _____

_____

☐ Total assistance in bathing.

Other considerations: _____

_____

DRESSING - Getting clothes from closets and drawers, including underclothes, outer garments, and using fasteners (including braces, if worn).

☐ I get my clothes and get completely dressed without assistance.

☐ I get my clothes and get completely dressed with adaptive devices. (*Please explain below.)*

☐ I get completely dressed by myself once clothes are set out.

I require cueing to complete dressing. Please explain cueing required.

☐ _____

_____

☐ I receive some assistance in getting clothes and getting dressed. (*Please explain assistance needed below.)*

☐ I receive total assistance in getting clothes and getting dressed.

Other considerations: _____

_____

GROOMING: HAIR

- ☐ I get out needed items and can comb/brush my hair myself.
- ☐ I can brush/comb my hair myself but need set-up.
  I need cueing to complete. Please explain cueing required.
- ☐ _____
  _____
- ☐ I need total assistance with brushing/combing my hair.

SHAVING

- ☐ I get out needed items and can shave myself.
- ☐ I can shave myself but need set-up.
  I need cueing to complete. Please explain cueing required
- ☐ _____
  _____
- ☐ I need total assistance with shaving.
- ☐ I typically use an electric razor.

ORAL HYGIENE

- ☐ I get out needed items and clean my teeth/dentures myself.
- ☐ I can clean my teeth/dentures myself but need set-up.
  I can clean my teeth/dentures myself but need cueing to complete.
  Please explain cueing required
- ☐ _____
  _____
  _____
- ☐ I need total assistance with cleaning my teeth/dentures.

TOILETING - Going to the "bathroom" for bowel and urine elimination, cleaning self after elimination, and arranging clothes.

- ☐ I require no assistance in toileting.
- ☐ I require assistance in getting to and from the "bathroom" only.
- ☐ I require assistance getting to and from the "bathroom", cleaning myself and/or in arranging clothes after elimination or in use of night bedpan or commode.

Other considerations: _____

_____

_____

_____

_____

CONTINENCE (Choose all that apply)

- ☐ I control urination completely by myself.
- ☐ I control bowel movements completely by myself.
- ☐ I occasionally lose control of: (If checked, mark one of the following)
  - ☐ bowel ☐ bladder ☐ both
- ☐ I **cannot** control urination.
- ☐ I **cannot** control bowel movements.
- ☐ I use adult incontinent protection such as Attends, Depends, or other incontinent pads. (If checked, mark one of the following)
  - ☐ I care for them myself ☐ I need assistance with changing
- ☐ I have a catheter. (If checked, mark one of the following)
  - ☐ indwelling ☐ external ☐ suprapubic
- ☐ I have a colostomy or ileostomy and can care for this myself.
- ☐ I have a colostomy or ileostomy and need assistance with this.

Other considerations: _____

_____

_____

COMMUNICATION/MEMORY:

- ☐ I have trouble communicating thoughts and/or I forget my words.
- ☐ People say they have trouble hearing or understanding me when I speak.
- ☐ I forget the topic of conversation or get confused during a conversation.
- ☐ I forget answers or instructions that were provided.
- ☐ I become frustrated and/or confused with too much information or too many steps.
- ☐ I have trouble keeping track of time or appointments.
- ☐ I don't function well in situations that are noisy or where many people are speaking at once.

I am hard of hearing. ☐ Yes ☐ No

☐ I wear hearing aids ☐ I do not wear hearings ☐ I have hearing aids, but do not wear them

I have trouble reading because:

☐ My vision is poor ☐ I need new glasses ☐ Words do not make sense

 Name: _____

ORIENTATION (**Choose all that apply)**

☐ Never confused or disoriented.

☐ Rarely confused or disoriented. Please describe. _____

☐ Sometimes confused, disoriented and forgetful. (To include functioning in familiar surroundings, but gets disoriented in new surroundings.) Please describe. _____

☐ Totally confused and disoriented. Please describe. _____

☐ I experience frequent periods of agitation such as yelling, hitting or throwing things. Explanation required: _____

_____

_____

_____

_____

Please mark the appropriate answers below:

1. Do you wander away and/or get lost? ☐ Yes ☐ No
   If yes, how often? _____ Please explain the circumstances: _____

   _____

   _____
2. Are you safe to be left alone at home *alone* for more than two hours? ☐ Yes ☐ No
3. Are you currently in a secure memory care area? ☐ Yes ☐ No
4. Do you wear a Wander Guard bracelet? ☐ Yes ☐ No
   ****If using a Wander Guard does the individual check doors or in some other way try to exit the facility? ☐ Yes ☐ No**
5. Are restraints currently being used? ☐ Yes ☐ No
   If yes, state type and frequency: _____

   _____

   _____

   _____

   _____

   _____

FOOD & NUTRITION SERVICES:

Height: _____ Weight: _____lbs. My usual weight is: _____lbs.

I have experienced significant changes in weight in the past 6 months: ☐ Yes ☐ No

If yes, describe: _____

_____

I have a food allergy or intolerance: ☐ Yes (list below) ☐ No

Food allergies (if any): _____

Food intolerance (if any): _____

I have special dietary needs related to my religion, culture or ethnicity: ☐ Yes ☐ No

If yes, please describe: _____

_____

IMPORTANT NOTICE: IVH does not offer holistic and/or organic foods and drinks. Residents may purchase these at their own expense if they wish

My appetite is generally: ☐ Good ☐ Fair ☐ Poor

My usual diet(s):

☐ Regular ☐ Heart Healthy

☐ Diabetic (Small portions diet available) ☐ Tube feeding: _____

☐ Renal/Dialysis (Modified Renal diet available)

I have difficulty chewing or swallowing: ☐ Foods ☐ Liquids ☐ Pills

Sometimes food or liquid goes down the wrong way (into my windpipe) and makes me cough or choke. ☐ Yes ☐ No

I have dental problems. ☐ Missing teeth ☐ Poor fitting dentures

I eat food or liquids with special textures: ☐ Yes ☐ No

If so, I eat foods prepared as follows:

☐ Soft foods ☐ Diced foods ☐ Pureed foods ☐ Thickened Liquids

FOOD & NUTRITION SERVICES Continued:

I avoid these problematic foods: _____

_____

I have problems with my esophagus: ☐ Yes ☐ No

I swallow okay, but then it gets stuck or won't go all the way down.

☐ Food/pills get stuck ☐ Esophageal stricture

☐ Heart burn/Acid Reflux ☐ Hiatal hernia

At meal time:

☐ I am independent at meal time. I can feed myself food and drinks.

☐ I need some help cutting food and/or opening containers, but can otherwise feed myself.

☐ I require some help to eat bites or to get a drink. Sometimes I need to be fed.

☐ I always need help in order to eat and drink.

☐ I get tired or lose interest in the meal before I am finished.

☐ I use adaptive tools at meals (e.g. weighted silverware, plate guard, etc.) ☐ Yes ☐ No

If yes, list adaptive tools: _____

Other considerations: _____

_____

MEDICATIONS (Choose all that apply)

☐ I take my own medications.

☐ I take my own medications after someone else sets them up.

☐ Need reminders to take medications. What mechanism is used to remind you to take medications?

☐ Someone else gives me my medications.

☐ I receive medications by injection.

☐ I receive my medications crushed.

Other considerations: _____

_____

OXYGEN

☐ Occasional Liter flow? _____ How often used? _____ ☐ Continuous Liter Flow? _____ ☐ Do not use

☐ CPAP/BiPAP ☐ Other

Please mark the appropriate response for oxygen use: ☐ Receive at bedside ☐ Portable

Are you compliant with your oxygen use? ☐ Yes ☐ No

Do you own your oxygen equipment? ☐ Yes ☐ No

If yes, who issued the equipment? Medicare ☐ DVA ☐ Personal Purchase ☐

Other considerations: _____

_____

MOBILITY

☐ I can walk two blocks with or without assistive devices independently.

☐ I require assistive devices to walk independently. (Mark all that apply)

☐ cane ☐ walker ☐ crutches

Distance able to walk with the use of assistive devices? _____

☐ I use a manual wheelchair and can operate it independently. Distance able to wheel manual wheelchair without assist? _____

☐ I use a manual wheelchair and require assistance to operate it.

☐ I use a walker and need assistance of one person to ambulate.

☐ I use a walker and need assistance of more than one person to ambulate.

☐ I have a power mobility device (electric wheelchair or scooter) that I use. Please see supplement related to power mobility devices at the Iowa Veterans Home.

Other considerations: _____

_____

TRANSFERS

☐ I get in and out of bed as well as in and out of a chair without assistance.

☐ I require assistance from one person to get in and out of bed or chair.

☐ I require assistance from more than one person to get in and out of bed or chair.

☐ I require a lift to get in and out of bed or chair. Type of lift needed:
Ceiling Lift ☐ Stand Lift ☐ Hoyer Lift ☐

☐ I can turn from side to side when in bed without assistance.

☐ I need assistance to turn from side to side when in bed.

Other considerations: _____

_____

FALL HISTORY

Have you had any recent falls? ☐ Yes ☐ No If yes, please explain the circumstances surrounding each fall: _____

_____

_____

If yes, how many falls have you had in the last 3 months? _____

Are these falls a change in baseline behavior? ☐ Yes ☐ No

When was your last fall? _____

PROSTHESIS

If you use prosthesis, please state type: _____

☐ Eyeglasses ☐ Hearing aids ☐ Dentures ☐ Other _____

I can apply my own prosthesis: ☐ Yes ☐ No

Other considerations: _____

_____

REHABILITATIVE SERVICES

Have you previously received or are you receiving rehabilitation treatment for a current physical condition? ☐ Yes ☐ No

Type of therapy received: _____

_____

_____

LOCATION DATES

_____

_____

MENTAL HEALTH

Are you under a court commitment? ☐ Yes ☐ No

If yes, please mark appropriate type: ☐ Inpatient ☐ Outpatient

Have you ever been hospitalized or received care in relation to mental health problems?

☐ Yes ☐ No

If yes, list name of doctor or agency: Date(s) Length of Stay

_____

_____

_____

_____

_____

_____

ALCOHOL/CHEMICAL DEPENDENCE

- ☐ I do not drink alcoholic beverages nor do I use other chemical substances and have no history of problems with these substances.
- ☐ I occasionally drink alcoholic beverages, but never to excess and have no history of problems with these substances.
- ☐ I have in the past, but not within the last year, and do not currently have problems with alcohol and/or chemical dependency.
- ☐ I currently have problems associated with alcohol and/or chemical dependency.

Have you consumed alcohol or chemical substances in the past 60 days? ☐ Yes ☐ No

If yes, what and how much?_____How often?_____

Please list treatment programs attended/completed and date(s):

_____

_____

Other considerations: _____

_____

TOBACCO USE

1) Do you smoke cigarettes, e-cigarettes, cigars or vape? ☐ Yes ☐ No

2) Do you chew tobacco or use snuff? ☐ Yes ☐ No

OTHER HEALTH CONSIDERATIONS

Presently I have: ☐ Pressure Ulcers ☐ Skin Rashes ☐ Injuries

Please describe: _____

_____

_____

Other considerations: _____

_____

Please provide the date of the most recent immunization below. If you have never received an immunization listed below, please indicate this. *Immunization records must be obtained prior to any potential admission.*

Tetanus (Td, Tdap)	Date: _____	Hepatitis B	Date: _____
Influenza	Date: _____	Zostavax	Date: _____
Prevnar 13	Date: _____	Shingrix 1	Date: _____
Pneumovax 23	Date: _____	Shingrix 2	Date: _____
Covid – 19	Date: _____		

List reaction(s) to any of the immunizations above _____

_____

Please answer the following questions to the best of your ability: (Mark yes or no)
If yes, please explain, including dates. Use available space on page 12, if needed.

1.	Have you had a TB skin test?	☐ Yes	☐ No	Date: _____
2.	Did you have a reaction?	☐ Yes	☐ No	
3.	Do you presently have or have you had a history of infection(s) and/or communicable disease(s)?	☐ Yes	☐ No	
4.	Do you presently have or have you had a history of having MRSA or VRE or any other resistive disease?	☐ Yes	☐ No	

If you answered yes to any question above, please explain, including dates:

_____

_____

Have you been diagnosed with the following illnesses?

Measles (Red Measles)	☐ Yes	☐ No	Date: _____
Mumps	☐ Yes	☐ No	Date: _____
Rubella (German Measles)	☐ Yes	☐ No	Date: _____
Pertussis (Whooping Cough)	☐ Yes	☐ No	Date: _____
Smallpox	☐ Yes	☐ No	Date: _____
Chicken Pox	☐ Yes	☐ No	Date: _____
Polio	☐ Yes	☐ No	Date: _____

THIS SPACE PROVIDED FOR ANY ADDITIONAL COMMENTS/INFORMATION YOU MAY HAVE:

Name: _____