VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates:
Screen: ____/____/________
Assessment: ____/____/________
Reassessment: ____/____/________

IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: ______________________ Client SSN: ______________
(Last) *(First)* *(Middle Initial)*

Address: ______________________
(Street) *(City)* *(State)* *(Zip Code)*

Phone: ______________ City/County Code: ______________

Directions to House: **Pets?**

Demographics

Birthdate: ____/____/____ *(Month) (Day) (Year)* **Age:** __________ **Sex:** ____ Male $_0$ ____ Female $_1$

Marital Status: ____ Married $_0$ ____ Widowed $_1$ ____ Separated $_2$ ____ Divorced $_3$ ____ Single $_4$ ____ Unknown $_9$

Race:
- ____ White 0
- ____ Black/African American 1
- ____ American Indian 2
- ____ Oriental/Asian 3
- ____ Alaskan Native 4
- ____ Unknown 9 ______________

Ethnic Origin: ______________

Education:
- ____ Less than High School 0
- ____ Some High School 1
- ____ High School Graduate 2
- ____ Some College 3
- ____ College Graduate 4
- ____ Unknown 9

Specify: ______________

Communication of Needs:
- ____ Verbally, English 0
- ____ Verbally, Other Language 1
- ____ Specify: ______________
- ____ Sign Language/Gestures/Device 2
- ____ Does Not Communicate 3

Hearing Impaired? ______________

Primary Caregiver/Emergency Contact/Primary Physician

Name: ______________ Relationships: ______________
Address: ______________ Phone: (H) ________ (W) ________
Name: ______________ Relationship: ______________
Address: ______________ Phone: (H) ________ (W) ________
Name of Primary Physician: ______________ Phone: ______________
Address: ______________

Initial Contact

Who called: ______________
(Name) *(Relation to Client)* *(Phone)*

Presenting Problem/Diagnosis:

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	(Check All Services That Apply)	Provider/Frequency:
____	____	Adult Day Care	____
____	____	Adult Protective	____
____	____	Case Management	____
____	____	Chore/Companion/Homemaker	____
____	____	Congregate Meals/Senior Center	____
____	____	Financial Management/Counseling	____
____	____	Friendly Visitor/Telephone Reassurance	____
____	____	Habilitation/Supported Employee	____
____	____	Home Delivered Meals	____
____	____	Home Health/Rehabilitation	____
____	____	Home Repairs/Weatherization	____
____	____	Housing	____
____	____	Legal	____
____	____	Mental Health (Inpatient/Outpatient)	____
____	____	Mental Retardation	____
____	____	Personal Care	____
____	____	Respite	____
____	____	Substance Abuse	____
____	____	Transportation	____
____	____	Vocational Rehab/Job Counseling	____
____	____	Other:	____

Financial Resources

Where are you on the scale for annual (monthly) family income before taxes?

	Annual	Monthly	Code
____	$20,000 or More	($1,667 or more)	0
____	$15,000 - 19,999	($1,250 - $1,666)	1
____	$11,000 - 14,999	($ 917 - $1,249)	2
____	$ 9,500 - 10,999	($ 792 - $ 916)	3
____	$ 7,000 - 9,499	($ 583 - $ 791)	4
____	$ 5,500 - 6,999	($ 458 - $ 582)	5
____	$ 5,499 or Less	($ 457 or Less)	6
	Unknown		9

Optional: Total monthly ____

Do you currently receive income from…?

No 0	Yes 1		*Optional: Amount*
____	____	Black Lung	____
____	____	Pension	____
____	____	Social Security	____
____	____	VA Benefits	____
____	____	Wages/Salary	____
____	____	Other	____

Does anyone cash your check, pay your bills

No 0	Yes 1		*Names*
____	____	Legal Guardian	____
____	____	Power of Attorney	____
____	____	Representative Payee	____
____	____	Other	____

Do you receive any benefits or entitlements?

No 0	Yes 1	
____	____	Food Stamps
____	____	General Relief
____	____	State and Local Hospitalization
____	____	Subsidized Housing
____	____	Tax Relief

What types of health insurance do you have?

____	____	Medicare, #	____
____	____	Medicaid, #	____
____	____	Pending:	____ No 0 ____ Yes 1
____	____	*QMB/SLMB:*	____ No 0 ____ Yes 1
____	____	All Other Public/Private:	____

Client Name:	Client SSN:

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone $_1$	Spouse $_2$	Other $_3$	Names of Persons in Household
____ House: Own $_0$				
____ House: Rent $_1$				
____ House: Other $_2$				
____ Apartment $_3$				
____ Rented Room $_4$				

	Name of Provider *(Place)*	Admission Date	Provider Number *(If Applicable)*
—— Adult Care Residence $_{50}$			
—— Adult Foster $_{60}$			
—— Nursing Facility $_{70}$			
___ Mental Health/Retardation Facility $_{80}$			
—— Other $_{90}$			

Where you usually live are there any problems?

No $_0$	Yes $_1$	*(Check All Problems That Apply)*	Describe Problems:
______	______	Barriers to Access	
______	______	Electric Hazards	
______	______	Fire Hazards/No Smoke Alarm	
______	______	Insufficient Heat/Air Conditioning	
______	______	Insufficient Hot Water/Water	
______	______	Lack of/Poor Toilet Facilities (Inside/Outside)	
______	______	Lack of/Defective Stove, Refrigerator, Freezer	
______	______	Lack of/Defective Washer/Dryer	
______	______	Lack of/Poor Bathing Facilities	
______	______	Structural Problems	
______	______	Telephone Not Accessible	
______	______	Unsafe Neighborhood	
______	______	Unsafe/Poor Lighting	
______	______	Unsanitary Conditions	
______	______	Other: ______________________	

Client Name:	Client SSN:

FUNCTIONAL STATUS *(Check only one block for each level of functioning.)*

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40			Is Not D .Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	Needs Help?		Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External D Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6
	No 00	Yes						
Bowel								
Bladder								

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40	Is Not D Performed 50
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	D Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt.		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

_____ No, Continue with Section 3 (0) _____ Yes, Service Referrals (1) _____ Yes, No Service Referrals (2)

Screener: ____________________ Agency: ____________________

Client Name:	*Client SSN:*

PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admission: In the past 12 months have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advance directives such as… (Who has it…Where is it…)?

No 0 Yes 1 *Location*

______ ______ ______________________

______ ______ Durable Power of Attorney for Health Care, ______________________

______ ______ Other, ______________________

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as … (Refer to the list of diagnoses)?

Current Diagnoses **Date of Onset**

______________________ ______________
______________________ ______________
______________________ ______________
______________________ ______________
______________________ ______________
______________________ ______________

Enter Codes for 3 Major, Active Diagnoses: _____ **None00** _____ **DX1** _____ **DX2** _____ **DX3**

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Total No. of Medications: _______ **(If 0, skip to Sensory Function)** **Total No. of Tranquilizer/Psychotropic Drugs:** __________

Do you have any problems with medicine(s)…?

No 0 Yes 1

______ ______ Adverse reactions/allergies
______ ______ Cost of medication
______ ______ Getting to the pharmacy
______ ______ Taking them as instructed/prescribed
______ ______ Understanding directions/schedule

How do you take your medications?

_______ Without assistance 0
_______ Administered/monitored by lay person 1
_______ Administered/monitored by professional nursing staff 2

Describe help: ______________________
Name of helper: ______________________

Diagnoses:
Alcoholism/Substance Abuse (01)
Blood-Related Problems (02)
Cancer (03)
Cardiovascular Problems
- Circulation (04)
- Heart Trouble (05)
- High Blood Pressure (06)
- Other Cardiovascular Problems (07)

Dementia
- Alzheimer's (08)
- Non-Alzheimer's (09)

Developmental Disabilities
- Mental Retardation (10)
- Related Conditions
  - Autism (11)
  - Cerebral Palsy (12)
  - Epilepsy (13)
  - Friedreich'a Ataxia (14)
  - Multiple Scierosis (15)
  - Muscular Dystrophy (16)
  - Spina Bifida (17)

Digestive/Liver/Gall Bladder (18)
Endocrine (Gland)Problems
- Diabetes (19)
- Other Endocrine Problem (20)

Eye Disorders (21)
Immune System Disorders (22)
Muscular/Skeletal
- Arthritis/Rheumatoid Arthritis (23)
- Osteoporosis (24)
- Other Muscular/Skeletal Problems (25)

Neurological Problems
- Brian Trauma/Injury (26)
- Spinal Cord Injury (27)
- Stroke (28)
- Other Neurological Problems (29)

Psychiatric Problems
- Anxiety Disorder (30)
- Bipolar (31)
- Major Depression (32)
- Personality Disorder (33)
- Schizophrenia (34)
- Other Psychiatric Problems (35)

Respiratory Problems
- Black Lung (36)
- COPD (37)
- Pneumonia (38)
- Other Respiratory Problems (39)

Urinary/Reproductive Problems
- Renal Failure (40)
- Other Urinary /Reproductive (41)

All Other Problems (42)

Client Name:	*Client SSN:*

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment $_0$	**Impairment** *Record Date of Onset/Type of Impairment*		**Complete Loss** $_3$	**Date of Last Exam**
		Compensation $_1$	No Compensation $_2$		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers, and legs?

________ Within normal limits or instability corrected $_0$
________ Limited motion $_1$
________ Instability uncorrected or immobile $_2$

Have you ever broken or dislocated any bones … Ever had an amputation or lost any limbs … Lost voluntary movement of any part of your body?

Fractures/Dislocations	**Missing Limbs**	**Paralysis/Paresis**
____ None 000	____ None 000	____ None 000
____ Hip Fracture 1	____ Finger(s)/Toe(s) 1	____ Partial 1
____ Other Broken Bone(s) 2	____ Arm(s) 2	____ Total 2
____ Dislocation(s) 3	____ Leg(s) 3	Describe: ________
____ Combination 4	____ Combination 4	
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
____ No/Not Completed 1	____ No/Not Completed 1	____ No/Not Completed 1
____ Yes 2	____ Yes 2	____ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
____ 1 Year or Less 1	____ 1 Year or Less 1	____ 1 Year or Less 1
____ More than 1 Year 2	____ More than 1 Year 2	____ More than 1 Year 2

Nutrition

Height: ________ *(Inches)* Weight: ________ *(lbs.)* Recent Weight Gain/Loss: ____ No $_0$ ____ Yes $_1$
Describe: ________________

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

No $_0$	Yes $_1$	
____	____	Food Allergies
____	____	Inadequate Food/Fluid Intake
____	____	Nausea/Vomiting/Diarrhea
____	____	Problems Eating Certain Foods
____	____	Problems Following Special Diets
____	____	Problems Swallowing
____	____	Taste Problems
____	____	Tooth or Mouth Problems
____		Other: ________

Client Name: *Client SSN:*

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as…?

No $_0$	Yes $_1$		*Frequency*
		Occupational	
		Physical	
		Reality/Remotivation	
		Respiratory	
		Speech	
		Other	

Do you have pressure ulcers?

		Location/Size
	None 0	
	Stage I 1	
	Stage II 2	
	Stage III 3	
	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as …?

No $_0$	Yes $_1$		*Site, Type, Frequency*
		Bowel/Bladder Training	
		Dialysis	
		Dressing/Wound Care	
		Eye care	
		Glucose/Blood Sugar	
		Injections/IV Therapy	
		Oxygen	
		Radiation/Chemotherapy	
		Restraints (Physical/Chemical)	
		ROM Exercise	
		Trach Care/Suctioning	
		Ventilator	
		Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ______ No $_0$ ______ Yes $_1$

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: ______________________ Date: ______________

Others: ______________________ Date ______________

(Signature/Title)

©Virginia Long-Term Care Council, 1994; reformatted May 2000, Virginia Department of Social Services

Client Name: *Client SSN:*

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: Please tell me your full name (so that I can make sure our record is correct).
Place: Where are we now (*state, county, town, street/route number, street name/box number*)? *Give the client 1 point for each correct response.*
Time: Would you tell me the date today *(year, season, date, day, month)*?

_____ Oriented 0
_____ Disoriented – Some spheres, some of the time 1
_____ Disoriented – Some spheres, all the time 2
_____ Disoriented – All spheres, some of the time 3
_____ Disoriented – All spheres, all of the time 4
_____ Comatose 5

Spheres affected: ____________________

Recall/Memory/Judgment

Recall: I am going to say three words. And I want you to repeat them after I am done (House, Bus,Dog). * Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* * Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/
Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: * Ask the client to recall the 3 words he was to remember.

Long-Term: When were you born (What is your date of birth)?

Judgment: If you needed help at night, what would you do?

No 0	Yes 1	
_____	_____	Short-Term Memory Loss?
_____	_____	Long-Term Memory Loss?
_____	_____	Judgment Problems?

Optional: MMSE Score

(5)

(5)

(3)

(5)

Total:

Note: Score of 14 or below implies cognitive impairment.

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc…) or become agitated and abusive?

_____ Appropriate 0
_____ Wandering/Passive – Less than weekly 1
_____ Wandering/Passive – Weekly or more 2
_____ Abusive/Aggressive/Disruptive – Less than weekly 3
_____ Abusive/Aggressive/Disruptive – Weekly or more 4
_____ Comatose 5

Type of inappropriate behavior: ____________________ Source of Information: ____________________

Life Stressors

Are there any stressful events that currently affect your life, such as …?

_____	_____	Change in work/employment	_____	_____	Financial problems	_____	_____	Victim of a crime
_____	_____	Death of someone close	_____	_____	Major illness- family/friend	_____	_____	Failing health
_____	_____	Family conflict	_____	_____	Recent move/relocation	_____	_____	Other: _____

Client Name:	*Client SSN:*

Emotional Status

In the past month, how often did you …?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living … or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite … that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0 ______ Yes 1 ______ *Describe* ______

______ ______ With Friends/Family, ______

______ ______ With Groups/Clubs, ______

______ ______ Religious Activities, ______

How often do you talk with your children family or friends either during a visit or over the phone?

Children

______ No Children 0

______ Daily 1

______ Weekly 2

______ Monthly 3

______ Less than Monthly 4

______ Never 5

Other Family

______ No Other Family 0

______ Daily 1

______ Weekly 2

______ Monthly 3

______ Less than Monthly 4

______ Never 5

Friends/ Neighbors

______ No Friends/Neighbors 0

______ Daily 1

______ Weekly 2

______ Monthly 3

______ Less than Monthly 4

______ Never 5

Are you satisfied with how often you see or hear from your children other family and/or friends?

______ No 0 ______ Yes 1

Client Name:	*Client SSN:*

Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves emotional/mental health alcohol or substance abuse problems?

_______ No 0 _______ Yes 1

Name of Place	Admit Date	Length of stay/Reason

Do (did) you ever drink alcoholic beverages?

____

_______ At one time, but no longer

_______ Currently 2

How much: ____________________

How often: ____________________

Do (did) you ever use non-prescription, mood altering substances?

but no longer 1

____

How often: ____________________

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

	Do (did) you ever use alcohol/other mood-altering substances with …	**Do (did) you ever use alcohol/other mood-altering substances to help you …**
______ No 0 ______ Yes 1	No 0 Yes 1	No 0 Yes 1
Describe concerns:	______ ______ Prescription drugs?	______ ______ Sleep?
	______ ______ OTC medicine?	______ ______ Relax?
	______ ______ Other substances?	______ ______ Get more energy?
		______ ______ Relieve worries?
	Describe what and how often:	______ ______ Relieve physical pain?
		Describe what and how often:

Do (did) you ever smoke or use tobacco products?

_______ Never 0

_______ At one time, but no longer 1

_______ Currently 2

How much: ____________________

How often: ____________________

Is there anything we have not talked about that you would like to discuss?

©Virginia Long-Term Care Council, 1994; reformatted May 2000, Virginia Department of Social Services

Client Name:	*Client SSN:*

Assessment Summary

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-55.3, to report this to the Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

______ No $_0$ (Skip to Section on Preferences) ______ Yes $_1$

Where does the caregiver live?

______ With client 0
______ Separate residence, close proximity 1
______ Separate residence, over 1 hour away 2

Is the caregiver's help …

______ Adequate to meet the client's needs? 0
______ Not adequate to meet the client's needs? 1

Has providing care to client become a burden for the caregiver?

______ Not at all 0
______ Somewhat 1
______ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preference for receiving needed care: ______________________________

Family/Representative's preference for client's care: ______________________________

Physician's comments (if applicable): ______________________________

Client Name:	*Client SSN:*

Client Case Summary

Unmet Needs

No 0	Yes 1	*(Check All That Apply)*
______	______	Finances
______	______	Home/Physical Environment
______	______	ADLS
______	______	IADLS

No 0	Yes 1	*(Check All That Apply)*
______	______	Assistive Devices/Medical Equipment
______	______	Medical Care/Health
______	______	Nutrition
______	______	Cognitive/Emotional
______	______	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: **Case assigned to:** ______________________________ **Code #:** ______________________

©Virginia Long-Term Care Council, 1994; reformatted May 2000, Virginia Department of Social Services