A Comprehensive Health Needs Assessment for Older Veterans

A wide variety of health and wellbeing programs are offered through the Department of Veterans' Affairs. Please refer to the DVA website at http://www.dva.gov.au/service_providers/services/Pages/health_services.aspx

Assessor: [Name]

Today’s Date: [Date]

PATIENT INFORMATION

Patient’s last name: [Last Name]
First: [First Name]
Middle: [Middle Name]
- Dr.
- Mr.
- Mrs.
- Miss
- Ms.

Marital status
- Single
- Married/Defacto
- Divorce/Separated
- Widowed

Street address: [Address]
Home phone no.: ( )
P.O. Box: [Box Number]
Suburb [Suburb]
State: [State]
Postcode: [Postcode]

Date of Birth: [Date of Birth]
Age (years) [Age]
DVA Card no.: [Card Number]

Gender
- M
- F

Is the patient a:
- Veteran
- War Widow/er
- Dependent

Legal documents
- Enduring Power of Attorney
- Enduring Power of Guardianship
- Medical Power of Attorney

LIVING ARRANGEMENTS

Are you living:
- Alone
- As a couple
- With family (specify) [Specify]
- With others (specify) [Specify]

OVERALL HEALTH AND WELL-BEING

How would you rate your overall health and well-being?
- Poor
- Fair
- Good
- Very good
- Excellent

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Notes for assessors

A patient with cognitive impairment or dementia may have difficulty completing the self-reported measures within this form and responses need to be interpreted in relation to the patient’s ability to understand constructs such as ‘isolation’, ‘anxiety’ and ‘hopelessness’. With the consent of the older person, a spouse or family member may be approached to provide further information about the patient’s psychosocial and cognitive function. If a spouse/carer assists in completing some measures, this should be noted at the top of the relevant page(s).

**GP Coc - Step 1 Patient Examination**

Unless specified, each question should only be asked once.

### Name and Address for Subsequent Recall Test

“I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes:

John Brown, 42 West Street, Kensington.” (Allow a maximum of 4 attempts).

### Time Orientation

*What is the date? (exact only)*

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
</table>

### Clock Drawing - Use the Diagram Provided on Page 3

*Please mark in all the numbers to indicate the hours of a clock (correct spacing required)*

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
</table>

*Please mark in hands to show 10 minutes past eleven o’clock (11.10)*

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
</table>

### Information

*Can you tell me something that happened in the news recently?*

Recently = in the last week. If a general answer is given, e.g. “war”, “lot of rain”, ask for details. Only specific answer scores.

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
</table>

### Recall

*What was the name and address I asked you to remember?*

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
</table>

### Total Correct (Score Out of 9)

<table>
<thead>
<tr>
<th>Incorrect</th>
<th>Correct</th>
</tr>
</thead>
</table>

If patient scores 9, no significant cognitive impairment and further testing not necessary.

If patient scores 5-8, more information required. Proceed with Step 2, informant section (see final page).

If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

---

### Hearing

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have difficulty with your hearing?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Pain

<table>
<thead>
<tr>
<th>Question</th>
<th>None</th>
<th>Very mild</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much bodily pain have you had during the last 4 weeks?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This question relates to 'usual' pain rather than infrequent or incident pain.

### Social

The next questions are about how you feel about different aspects of your life. For each one, tell me how often you feel that way.

<table>
<thead>
<tr>
<th>Question</th>
<th>Hardly ever</th>
<th>Some of the time</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you feel that you lack companionship?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>How often do you feel left out?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>How often do you feel isolated from others?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total (sum of the 3 items; higher scores indicate greater loneliness)

Who would be able to help you if there was an emergency or accident?

---


If the response to item 2 is ‘none of the time’, the response to item 3 will also be ‘none of the time’. Similarly, if the response to item 5 is ‘none of the time’, the response to item 6 will also be ‘none of the time’.

In the past 4 weeks:

<table>
<thead>
<tr>
<th></th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Subtotal (sum scores in each column)

Total score

A score ≥20 is considered “positive” for mental health disorder

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**POSTTRAUMATIC MENTAL HEALTH**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have had nightmares about it or thought about it when you did not want to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were constantly on guard, watchful, or easily startled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt numb or detached from others, activities, or your surroundings?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total (sum of ‘yes’ responses)

In primary care, the screening test is considered “positive” if a patient answers "yes" to any 2 items.

Reproduced with permission from the National Center for PTSD at [www.ptsd.va.gov](http://www.ptsd.va.gov).

**SEXUAL HEALTH** (optional)

In the past 3 months or more

Are you satisfied with your sexual function?  

If No please continue

How long have you been dissatisfied with your sexual function?

Would you like to talk about it with your healthcare provider?  


**Informal Care**

In the last 12 months, have you been a carer to someone who lives with you?  
☐ No  ☐ Yes

In the last 12 months, have you been a carer to someone who does not live with you?  
☐ No  ☐ Yes

**If yes** to either of the above questions, 
Would you like to talk about services that can support you in your role as a carer?  
☐ No  ☐ Yes

Do you currently have a carer?  
☐ No  ☐ Yes

Does your carer live with you?  
☐ No  ☐ Yes

Is your carer your spouse, son, daughter, other? (specify) ____________________________  
☐ No  ☐ Yes

If you have a carer, is there any aspect of your relationship with your carer that you would like to talk about?  
☐ No  ☐ Yes

If the carer is present, consider deferring this question until another time.

---

**Smoking**

How many cigarettes do you smoke a day?  
☐ None  ☐ 1-10  ☐ 11-15  ☐ 16-20  ☐ more than 20

Are you interested in quitting?  
☐ Yes  ☐ No  ☐ Unsure

---

ALCOHOL \textsuperscript{10,11} AND OTHER SUBSTANCES

How often do you have a drink containing alcohol?

- □ Never (0)  (Go to next question)
- □ Monthly or less (1)
- □ 2-4 times a month (2)
- □ 2-3 times a week (3)
- □ 4 or more times a week (4)

How many standard drinks containing alcohol do you have on a typical day?

- □ 1 or 2 (0)
- □ 3 or 4 (1)
- □ 5 or 6 (2)
- □ 7 to 9 (3)
- □ 10 or more (4)

How often do you have six or more drinks on one occasion?

- □ Never (0)
- □ Less than monthly (1)
- □ Monthly (2)
- □ Weekly (3)
- □ Daily or almost daily (4)

Total (sum the scores in brackets, for selected items)

In men, a score $\geq 4$ is considered “positive” for hazardous drinking.
In women, a score $\geq 3$ is considered “positive” for hazardous drinking.

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\textsuperscript{11} Babor, T. F. et al. (2001). AUDIT, the Alcohol Use Disorders Identification Test. Guidelines for Use in Primary Care, Retrieved from: \url{http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf}. 
### Other Substances

In the past year, how many times have you used the following?

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Once or twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prescription drugs for non-medical reasons</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Illegal drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does the use of alcohol or drugs cause any problems in your life? (e.g. friends, family, money, other)

- [ ] No
- [ ] Yes

If yes, would you like some assistance in managing this issue?

- [ ] No
- [ ] Yes

### Nutrition

Have you (without wanting to) lost or gained 5kg (about one stone) in the last 6 months?

- [ ] No
- [ ] Yes

In the last 12 months, were there any times that you ran out of food and couldn't afford to buy more?

- [ ] No
- [ ] Yes

Do you have any problems with your teeth, mouth or dentures?

- [ ] No
- [ ] Yes

Do you eat alone most of the time?

- [ ] No
- [ ] Yes (1)

How many meals a day do you usually eat?

- [ ] 3 or more
- [ ] 2 or less (1)

Do you eat fruit, vegetables and dairy products most days?

- [ ] No (1)
- [ ] Yes

Do you have 6-8 cups of fluid most days?

- [ ] No (1)
- [ ] Yes

Total (sum the scores in brackets, for selected items)

If the score is 3 or more, consider dietetic referral

---


13 Veterans Home Care Assessment 2011


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### PHYSICAL ACTIVITY

How many times a week do you usually do 30 minutes or more of moderate-intensity physical activity or walking that increases your heart rate or makes you breathe harder than normal?

- None
- 1-2 times
- 3-4 times
- 5 or more
- Not appropriate

### HEALTH LITERACY

How confident are you filling out medical forms by yourself?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Extremely

### IMMUNISATION

Have you been immunised against influenza?

- No
- Unsure
- Yes

Have you been immunised against tetanus?

- No
- Unsure
- Yes

Have you been immunised against pneumococcal pneumonia?

- No
- Unsure
- Yes

Have you been immunised against herpes zoster (which can cause shingles)?

- No
- Unsure
- Yes

**Notes for assessors**
Print the patient’s immunisation history and medications from your practice software and confirm with the patient during the home visit.

---

**Medications**

Print a summary of the patient's medications from your medical software and check for accuracy during the home visit.

In the past month, how often did you take your medications as the doctor prescribed?

- [ ] Less than half the time (≤ 50%)
- [ ] About half the time (50%)
- [ ] Most of the time (75%)
- [ ] Nearly all of the time (90%)
- [ ] All of the time (100%)

In the last 4 weeks, what over-the-counter medications have you taken? (specify)

Have you had to stop any of your medications for any reason?

- [ ] No
- [ ] Yes

If yes, which medications and why?

Have you noticed any side effects from your medications?

- [ ] No
- [ ] Yes

If yes, what side effects?

Do you have someone to help manage your medications?

- [ ] No
- [ ] Yes

If yes, who/what assistance?

- [ ] Webster pack
- [ ] Dosette prepared by
- [ ] Other (specify)

Assessor

Does the patient take 5 or more medications?

- [ ] No
- [ ] Yes

Does the patient use any medication devices (e.g., inhaler, spacer)?

- [ ] No
- [ ] Yes

Does the patient experience difficulty managing their medications (e.g., poor visual acuity or problems with swallowing, dexterity or cognition)?

- [ ] No
- [ ] Yes

If yes, specify

Recommend Home Medicine Review?

- [ ] No
- [ ] Yes

---


## FALLS

Have you had a fall in the past 12 months?
By a fall we mean a slip or trip in which you lose your balance and land on the floor or ground, including falls even when you were not hurt.

If Yes, did you have an injury as a result of the fall?

If yes, please specify injury

Are you afraid of falling?

---

## ACTIVITIES OF DAILY LIVING

Do you have any difficulties (or emerging difficulties) in any of the following mobility areas?

<table>
<thead>
<tr>
<th>Activity</th>
<th>What aids do you use?</th>
<th>Further aids required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving around the house</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Walking outside the house</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Walking up and down stairs</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Getting in or out of bed or a chair</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Do you have any difficulties (or emerging difficulties) in any of the following personal care areas?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who helps you?</th>
<th>Further services required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Grooming</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Bathing/Showering (getting in and out and the task of bathing)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Toileting</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Eating</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

---

23 Adapted from the Older Americans Resources and Services (OARS) Multidimensional Functional Assessment Questionnaire (Duke University 1975, Revised 1988)
### Instrumental Activities of Daily Living \(^{24,25}\)

<table>
<thead>
<tr>
<th>Activity</th>
<th>No</th>
<th>Yes</th>
<th>Who helps you?</th>
<th>Further services required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal preparation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing finances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Continence \(^{26}\)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any bladder or bowel issues that affect your lifestyle, for example incontinence?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please specify:

---


\(^{25}\) Adapted from the Older Americans Resources and Services (OARS) Multidimensional Functional Assessment Questionnaire (Duke University 1975, Revised 1988).

## SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>Is follow-up needed?</th>
<th>Comment/ Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Information</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Overall Health and Well Being</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>GPCOG – Step 1 (Patient)</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>GPCOG – Step 2 (Informant)</td>
<td>□ No □ Yes</td>
<td>Only required if patient score is 5-8</td>
</tr>
<tr>
<td>Hearing</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Distress</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Posttraumatic Mental Health</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Sexual Health</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Informal Care</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Alcohol and other substances</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Physical Activity</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Health Literacy</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Immunisation</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>ADLs</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Instrumental ADLs</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Continence</td>
<td>□ No □ Yes</td>
<td></td>
</tr>
</tbody>
</table>

## GPCOG - Informant Interview

*□ ONLY REQUIRED IF PATIENT SCORE IS 5-8*

<table>
<thead>
<tr>
<th>Patient consent to seek informant interview?</th>
<th>□ No</th>
<th>□ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informant’s relationship to patient, i.e. informant is the patient’s:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compared to a few years ago:</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>1. Does the patient have more trouble remembering things that have happened recently than s/he used to?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Does he or she have more trouble recalling conversations a few days later?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Is the patient less able to manage his or her medication independently?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Does the patient need more assistance with transport (either private or public)?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>(If the patient has difficulties due only to physical problems, e.g bad leg, tick ‘no’)</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

(To get a total score, add the number of items answered *no, don’t know or N/A*)

**Total score** (out of 6) | / 6

Higher scores indicate less impairment.

If the score on the informant interview is 0-3, cognitive impairment is indicated. Conduct standard investigations.

---