Medical Assessment of Alleged Elder Abuse

Client name:

Date of birth:

Referring source/name:

Type of alleged abuse:

Purpose of evaluation:

Background Narrative (reason for referral to EAFC):

Date of evaluation:

Persons present: .

Location:

Written/Verbal Permission granted: ……acting as a witness.

Medical Hx (pertinent):

Medications	Doses	How administered	Compliance

FUNCTION

Activities of Daily Living

	Independent	Partialassist/Reason	Total assist/Reason
Dressing			
Bathing			
Feeding			
Toileting			
Transfering			

___ _ Independent with ADLs (Fall risk, right shoulder range of motion limitation.

Intermediate Activities of Daily Living

	Independent	Partialassist/Reason	Total assist/Reason
Shopping			
Telephoning			
Finances			
Cooking			

____ Independent with IADLs

Environment:

Pertinent physical exam:

Cognitive assessment (see attached form for actual test):

MMSE total _____

Errors include

Clock draw total _____,

Interview with client:

Medical Record Review (Facility/Dates) (If applicable):

Assessment:

Recommendations:

Thank you for your kind referral to VAST.
If you have further questions or concerns regarding ……., please do not hesitate to contact me.

Sincerely,

Geriatrician