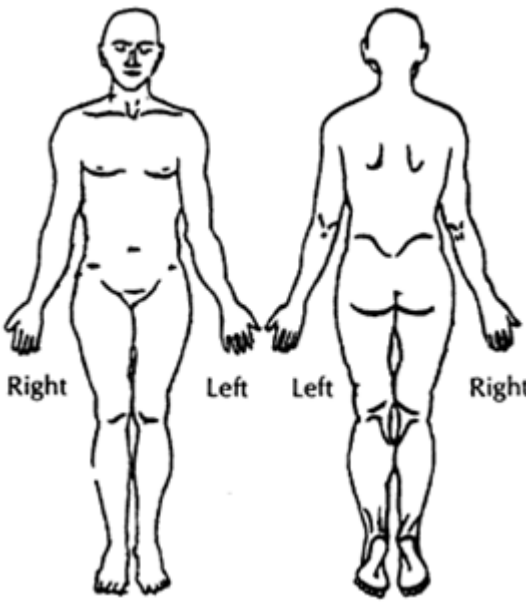


**KEMENTERIAN KESIHATAN MALAYSIA
PHYSIOTHERAPY DEPARTMENT
GERIATRIC ASSESSMENT FORM**

Name :----- Age: ----- Sex: M / F R/N:----- Date:-----

<p>DOCTOR'S DIAGNOSIS :</p>	<p>Fall History : H/O Fall in past 1 year : <input type="checkbox"/> YES <input type="checkbox"/> NO Consequence of fall :</p>
<p>DOCTOR'S MANAGEMENT :</p>	<p>CURRENT HISTORY</p>
<p>CURRENT COMPLAINT / PROBLEM :</p>	<p>PAST HISTORY</p>
<p>SUBJECTIVE ASSESSMENT : Medical history : HPT DM CCF IHD PVD COPD DEMENTIA PD OLD CVA (RT. / LT) OA FRACTURE</p>	<p>BODY CHART</p>
<p>SOCIAL HISTORY :</p>	
<p>Previous Surgery : YES / NO : Area _____</p>	
<p>IX / MRI / X-RAY / CT BRAIN / BMD / BIA :</p>	
<p>Medication :</p>	
<p>Main Carer : Husband / Wife / Son / Daughter / Sibling / Other : _____</p>	
<p>Premobid Mobility : Independent / Semi Independent / Dependent</p>	
<p>Current Mobility : Independent / Semi Independent / Dependent</p>	
<p>Home Environment <input type="checkbox"/> Lift <input type="checkbox"/> Stairs <input type="checkbox"/> Kerbs <input type="checkbox"/> Ground level</p>	
<p>Toilet : <input type="checkbox"/> Sitting <input type="checkbox"/> Squatting <input type="checkbox"/> Commode</p>	
<p>Walking Aids : <input type="checkbox"/> Walking Frame <input type="checkbox"/> Quadripod <input type="checkbox"/> Stick Others : _____</p>	
<p>Incontinence : Bladder : YES / NO Bowel : YES / NO <input type="checkbox"/> Stress <input type="checkbox"/> Urge <input type="checkbox"/> Mixed</p>	
<p>Wear Diapers : YES / NO Day : <input type="checkbox"/> Night : <input type="checkbox"/></p>	
<p>Dominant Hand : Right / Left</p>	<p>Presence of pain : YES / NO Pain Score : _____</p>
<p>Cognitive Impairment : YES / NO MMSE / Mini COG Test : _____</p>	<p>Pain Site :</p>
<p>Communication Impairment : Expressive / Receptive / None</p>	<p>Nature of pain : constant / intermittent / episodic</p>
<p>Visual Field Deficit : YES / NO Hearing Deficit : YES / NO</p>	<p>Type of pain : sharp / dull / superficial / deep</p>
<p>Other assistive Device : Pacemaker / Hearing aids / spectacles / dentures</p>	<p>Pain History : improve / unchanged / worsened</p>

OBJECTIVE ASSESSMENT

<p>Posture :</p> <p>Gait:</p> <p>Functional Mobility :</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"></td> <td style="width:10%; text-align: center;">Ind</td> <td style="width:10%; text-align: center;">Sup</td> <td style="width:10%; text-align: center;">Min A</td> <td style="width:10%; text-align: center;">Mod A</td> <td style="width:10%; text-align: center;">Max A</td> </tr> <tr> <td>Bed Mobility :</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sitting ↔ Standing :</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Transfer (Bed ↔ W/C):</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Ind	Sup	Min A	Mod A	Max A	Bed Mobility :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting ↔ Standing :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfer (Bed ↔ W/C):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Lungs :</p> <p>General Muscle Strength : Upper Limb :</p> <p style="text-align: right;">Lower Limb :</p> <p>ROM : Any contractures (Yes/No) : Area : _____</p> <p>Reflex : <input type="checkbox"/> Intact <input type="checkbox"/> Absent</p> <p>Sensation: Intact (Yes / No) :.....</p> <p>Proprioception: Intact (Yes / No) :.....</p>
	Ind	Sup	Min A	Mod A	Max A																				
Bed Mobility :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
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Transfer (Bed ↔ W/C):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				

OUTCOME MEASURE

		Date	Date	Date	Remarks
Balance	Berg's Balance Scale	/56	/56	/56	
	Timed Up and go Test	sec	sec	sec	
	Single Leg Stance	sec	sec	sec	
Strength	Grip Strength (kg)	R : L :	R : L :	R : L :	
	Chair rising (5x)	sec	sec	sec	
Mobility & Gait	Elderly Mobility Scale	/20			
	Problem Orientated Mobility Assessment				
Physical Performance	3 / 6 Min Walk Test	meter	meter	meter	
	Gait Speed (10 meter walk test)	No. of step :	No. of step :	No. of step :	
		Time of Speed :	Time of Speed :	Time of Speed :	
Flexibility	Chair Sit and Reach (cm)	R : L :	R : L :	R : L :	

PHYSIOTHERAPY IMPRESSION	SHORT TERM GOALS
LONG TERM GOALS	PLAN OF TREATMENT

Patient / carer agreeable to propose treatment: Yes / No

Attending Physiotherapist:

Patient Education Given : YES / NO

**KEMENTERIAN KESIHATAN MALAYSIA
GUIDELINES FOR USE OF GERIATRIK ASSESSMENT FORM**

DIAGNOSIS

- As in referral

DOCTOR'S MANAGEMENT

- Brief conservative or operative management

CURRENT COMPLAINT / PROBLEM

- What is the presenting complaint?
- Pain, Stiffness, Weaknessetc.
- Patient's orientated goal or aim

SUBJECTIVE ASSESSMENT

Any other medical history ?

SOCIAL HISTORY

- Any previous surgery
- Any investigation taken
- Who is the main carer?
- Premorbid Mobility ?
- Current mobility?
- Home environment?
- Type of toilet?
- Walking aids used?
- Types of incontinence
- Any diapers?
- What is the dominant hand?
- Any cognitive impairment?
- Any communication impairment?
- Any visual deficit?
- An other assistive device?
- Any history of fall?
-

CURRENT HISTORY

- How did the injury occur?
- When did it occur?
- Is it better or worse now?

PAST HISTORY

- Relevant past history with regards to the presenting problem
- Has it occurred before?
- Onset, progression, physiotherapy treatment and effect

OBSERVATION

- Willingness and ability to use the hand
- The posture of the hand at rest
- The bone and soft tissue contours of the forearm, Wrist and hand.
- Any localized swelling.
- Any Vasomotor changes (e.g. Loss of hair on the hand, Brittle finger nails, Increase or decrease in sweating of the palm, shiny skin)

- Scars, indicate recent surgery or past injury.

BODY CHART

-mark the body chart

PAIN

- Any presence of pain
- Nature of pain
- Type of pain
- Pain history?

SUBJECTIVE ASSESSMENT

- Posture
- gait
- functional mobility
- bed mobility
- sitting to standing
- transfer
- lungs
- general muscle strength
- range of motion
- reflex
- sensation intact
- proprioception

OUTCOME MEASURE

1. Balance- Berg balance scale, timed up and go test and single leg stance
2. Strength – grip strength, chair rising
3. Mobility and gait – elderly mobility scale, problem orientated mobility assessment
4. Physical performance – 3/6 min walk test, gait speed (10 meter)
5. Flexibility- chair sit and reach

PHYSIOTHERAPIST'S IMPRESSION

- Problem in order of priority.

SHORT TERM GOALS

- The goals which are set according to priority.
- Must include the expected outcomes and time frame.

LONG TERM GOALS

- The goals which are set for a longer time frame based on patient goals and physiotherapist goals.

PLAN OF TREATMENT

- The physiotherapy treatment that will be given according to the goal set.

SIGN/ STAMP/DATE

- Need to be filled by attending physiotherapist.