Print Form

Vancouver CoastalHealth
*Promoting wellness. Ensuring care.*

PARIS
PRIMARY ACCESS
Regional Information System

## INTAKE SCREENER V2 - FULL

| | | | |
|---|---|---|---|
| **Name:** | | **PARIS ID:** | |
| **DOB:** | **Age:** | **PHN:** | |
| **Gender:** | | **Phone:** | |
| **Home Address:** | | | |

**Assessment Start Date:** **Assessment End Date:** **Carried Out By:**

### Current Health Status

**What is the reason for referral / What is the reason for referral / hospitalization?**

### Goals of Care

Key Concerns / Identified expectations - Client's? Family? Support's?

### Surgeries/Procedures

*This section will continue to update after the assessment has been completed.*

| Surgeries/ Procedures | If Other | Date | Details | Recorded By | Date Recorded | Team |
|---|---|---|---|---|---|---|
| | | | | | | |

### Palliative Status

| | | | |
|---|---|---|---|
| Palliative Status | ☐ Yes | ☐ No | ☐ Possible |
| Client Aware | ☐ Yes | ☐ No | |
| Family Aware | ☐ Yes | ☐ No | |
| BC Palliative Care Benefits Program (BCPCBP) | ☐ Yes | ☐ No | |



**Assessment ID:**

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**Name:** **PARIS ID:**

### Prognosis

*This section will continue to update after the assessment has been completed.*

| Recorded By | Record Date | Prognosis | End Date | Entered at time of Registry? |
|---|---|---|---|---|
| | | | | |

### Eligibility Criteria

**Eligibiliy Criteria** No Assessed No Concern Concern

Aware of fee for service based on income level? Yes No

Recent income tax return available? Yes No

Comments:

### Physical Status

**Cardiovascular / Respiratory** Not Assessed Not Concern Concern

Comments:

**Skin Integrity** Not Assessed No Concern Concern

**VAC Therapy**

- Client has been on VAC therapy in acute care and the Wound Clinician or designate has deemed the appropriate treatment for this client is VAC therapy
- Client has participated in decision to maintain VAC therapy at home
- Client or family who are living with the client are capable and willing to learn basic management of the equipment at home

Goal: Prep for surgical closure Prep for graft / flap Wound healing

Incision / fistula closure Other

Etiology:

Wound Location:

Length: Width: Depth:

Wound Base Granulation %: Granulation: Slough:

Blood Work: Prealb: Alb: Hgb:

Treatment prior to VAC:

VAC Pressure Setting: mmHg Intermittent Continuous

Foam Size: Small Medium Large Other

Foam Type: Granufoam (Black) White Both

Number of Canisters/Week:

VAC has been applied in facility VAC to be initiated in community

Other Comments: (re: VAC Therapy)

Name: PARIS ID:

Skin Integrity Comments:

**Pain** ☐ Not Assessed ☐ No Concern ☐ Concern

Pain Symptoms ☐ Yes ☐ No

Adequate pain management? ☐ Yes ☐ No

Comments:

**Sleep** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

**Nutrition** ☐ Not Assessed ☐ No Concern ☐ Concern

Has there been unexpected weight loss? ☐ Yes ☐ No

Has the client not eaten in the last 3 days? ☐ Yes ☐ No

**Enterral Nutrition Information** ☐

Goals of Enteral Feeding: ☐ Maintenance ☐ Repletion ☐ Palliation

Expected duration of enteral feeding:

**Tube Feeding Regimen on Discharge**

Type and Size of Tube:

End Point of Tube:

Insertion Date:

Formula(s):

Person Responsible for Administering Tube Feeding: ☐ Client ☐ Caregiver

Schedule: ☐ Intermittent ☐ Continuous ☐ Nocturnal ☐ Gravity ☐ Pump

Details:

Nutrition Comments:

Name: PARIS ID:

**GI Disturbance** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

**Bowel / Urinary** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

## Functional Status

**Vision / Hearing** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

**Falls Risk** ☐ Not Assessed ☐ No Concern ☐ Concern

Client has fallen in last 90 days ☐ Yes ☐ No

Comments:

**Mobility / Transfers** ☐ Not Assessed ☐ No Concern ☐ Concern

| | Independent | Independent with Aids | Assist | Dependent |
|---|---|---|---|---|
| Repositioning in Bed | ☐ | ☐ | ☐ | ☐ |
| Lie to Sit | ☐ | ☐ | ☐ | ☐ |
| Sit to Stand | ☐ | ☐ | ☐ | ☐ |
| Ambulation | ☐ | ☐ | ☐ | ☐ |
| Stair Climbing | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ |

If Other, Specify:

Comments:

## INTAKE SCREENER V2 - FULL

**Name:** **PARIS ID:**

**Personal Care and ADLS** ☐ Not Assessed ☐ No Concern ☐ Concern

| | Independent | Independent with Aids | Assist | Dependent |
|---|---|---|---|---|
| Bathing | ☐ | ☐ | ☐ | ☐ |
| Toileting | ☐ | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ | ☐ |
| Meal Prep | ☐ | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ | ☐ |

Comments:

**IADL** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

**Equipment Issued** *This section will continue to update after the assessment has been completed.*

| Equipment Type | Equipment Item | Urgency | Period of loan (weeks) | Due Date | Competent with Equipment | Recorded By |
|---|---|---|---|---|---|---|
| | | | | | | |

**Allergies - Current** *This section will continue to update after the assessment has been completed.*

| A / S | Date Entered | Allergen | Reaction | Comment |
|---|---|---|---|---|
| | | | | |

**Medication Management** Medications -See Medication Module

Medication Management ☐ Not Assessed ☐ No Concern ☐ Concern

☐ Medication Management ☐ Access Device / IV Management

☐ IV Infusion ☐ Access Device Maintenance ☐ TPN ☐ SC ☐ IT

☐ Gravity ☐ Pump

**Maintenance Details**

Type: Site:

## INTAKE SCREENER V2 - FULL

**Name:** **PARIS ID:**

Tip Location: Lumen:

Date of Insertion: Last Dressing Change:

# cm at site: Last Tubing Change:

**Pump Details**

Res Vol (mL): Dose Vol (mL):

Dose Cycle (hr): TKVO (/hr):

Dose Duration (mins): Dose Rate (mL/hr):

Details:

Medication Management Comments:

**Medications - see Client Medication Report**

**Tests/Diagnostics** *This section will continue to update after the assessment has been completed.*

| Type | Test/Diagnostics 2 | If Other | Date of App. | Result Outcome | Recorded By | Date Recorded | Team |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**Diagnosis** *This section will continue to update after the assessment has been completed.*

| Date | Diagnosis Type | Diagnosis | State | Aware? | Comments |
|---|---|---|---|---|---|
| | | | | | |

**Past Relevant Health Hx**

**Past Health Hx** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

**Psychosocial Status**

**Current Living Situation** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

## INTAKE SCREENER V2 - FULL

**Name:** **PARIS ID:**

**Emotional** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

**Cognitive** ☐ Not Assessed ☐ No Concern ☐ Concern

Short Term Memory: ☐ Mild Impairment ☐ Significant Impairment

☐ Insight Concerns

Comments:

**Adult Guardianship** ☐ Not Assessed ☐ No Concern ☐ Concern

Comments:

**Potential Safety Concerns / Risks For Staff**

☐ Not Assessed ☐ No Concern ☐ Concern

**Referral Summary**

**Location of Care**

☐ Home Visit Reason: ☐ Ambulatory Clinic Visit

Comments:

**Identified Concerns**

**Client Education / Information Provided:**

**Follow-up Appointment** *This section will continue to update after the assessment has been completed.*

| Type Of App. | Date Of App. | Details | Recorded By | Team |
|---|---|---|---|---|
| | | | | |

| Name: | | PARIS ID: | |
|---|---|---|---|

**Additional Faxed Attachments with Referral & Additional Information**

- ☐ Financial
- ☐ Medication/Profile Summary or MAR
- ☐ Medical Consults
- ☐ Nursing Consultation (IV, Ostomy or Wound)
- ☐ Lab Results
- ☐ Physician Orders
- ☐ PT / OT / Other Notes
- ☐ Radiology

Additional Information / Intake Outcome :

## INTAKE SCREENER V2 - FULL

| Name: | | PARIS ID: | |
|---|---|---|---|

**Casenotes**

*May have been added after assessment completed.*

**Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.**

---------- End of Report ----------



Assessment ID: