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| **Medicare Benefits Schedule (MBS)**  **Comprehensive medical assessment (CMA) for residents of residential aged care facilities (RACF)**  **Proforma** |

*The use of this Proforma is* ***not*** *mandatory. GPs undertaking the Comprehensive Medical Assessment for residents of residential aged care facilities should refer to the relevant MBS Explanatory Notes for health assessment items 701, 703, 705 and 707 before using this Proforma.*

**Resident details**

|  |  |
| --- | --- |
| Resident’s name |  |
| Male/Female |  |
| Date of Birth |  |
| Age |  |

**Current contact details**

|  |  |
| --- | --- |
| Residential Aged Care Facility (RACF) - name, address and phone number |  |
| Pension number |  |
| Next of kin/guardian – name and phone number |  |

**Carers contact details**

|  |  |
| --- | --- |
| Name/s |  |
| Address |  |
| Phone number |  |
| Consultation undertaken with carer? | Yes/No |

**Power of attorney (recommended)**

|  |  |
| --- | --- |
| Advance Care Directive (or similar) | Yes/No |
| Enduring Medical Power of Attorney | Yes/No |

**New or existing resident (mandatory)**

|  |  |
| --- | --- |
| New | Yes/No |
| Existing | Yes/No |
| If existing, reason for CMA |  |

**Previous (recommended)**

|  |  |
| --- | --- |
| Has the resident had a previous CMA? | Yes/No |
| If yes, when (date)? |  |
| Service provided by (Dr’s details) |  |

**Resident consent (mandatory)**

|  |  |
| --- | --- |
| Explanation of CMA given? | Yes/No |
| Consent for CMA given? | Yes/No |
| Consent given for information to be collected by a nurse | Yes/No |
| Consent given for information to be collected by another health practitioner | Yes/No |
| Consent given by? | Resident/Carer |
| Date consent was given |  |

**Detailed medical history (mandatory)**

|  |  |
| --- | --- |
| Results of relevant previous assessments (eg, GPs, specialists and/or community based assessments) |  |

|  |  |
| --- | --- |
| Results of relevant previous investigations and allied health interventions |  |

|  |  |
| --- | --- |
| Results of assessment and intervention by nursing staff of the RACF |  |

|  |  |
| --- | --- |
| Details of allergies and any drug intolerance |  |

|  |  |
| --- | --- |
| Resident’s current medication (including prescribed and non-prescribed medication – drug chart can be attached) |  |

|  |  |
| --- | --- |
| Acute and chronic pain |  |

|  |  |
| --- | --- |
| Falls in the last three months |  |

**Immunisation status**

|  |  |
| --- | --- |
| Influenza – current? | Yes/No |
| Tetanus – current? | Yes/No |
| Pneumococcus – current? | Yes/No |

**Continence**

|  |  |
| --- | --- |
| Urinary | Normal/Abnormal |
| Urine test | Normal/Abnormal |
| Faecal | Normal/Abnormal |
| Any identified issues? |  |

|  |  |
| --- | --- |
| Factors leading to the admission into the RACF |  |

**Immediate action required**

|  |  |
| --- | --- |
| Cardiovascular system |  |
| Respiratory system |  |
| Pain |  |
| Physical function |  |
| Psychological function |  |
| Oral health |  |
| Nutrition status |  |
| Skin integrity |  |
| Continence |  |

**Other services required**

|  |  |
| --- | --- |
| Chronic Disease Management Care Plan required | Yes/No |
| Multidisciplinary Case Conference required | Yes/No |
| Medication Management Review required | Yes/No |
| Other services required |  |

**Next appointment with doctor**

|  |  |
| --- | --- |
| Date of appointment |  |
| GPs name |  |
| GPs signature & date |  |

**Comprehensive Medical Examination (mandatory)**

|  |  |
| --- | --- |
| **Cardiovascular system** | Normal/Abnormal |
| Identified issues |  |

|  |  |
| --- | --- |
| **Respiratory system** | Normal/Abnormal |
| Identified issues |  |

|  |  |
| --- | --- |
| Pain – acute | Yes/No |
| Pain – chronic | Yes/No |
| If yes, cause of pain |  |

|  |  |
| --- | --- |
| Physical function (including activities of daily living eg, walking, eating, dressing, personal care, bathing) – identified issues |  |

**Psychological function**

|  |  |
| --- | --- |
| Mood | Normal/depressed/other |
| Cognition | Normal/impaired/test for screening tool used |
| Identified issues |  |

**Oral health**

|  |  |
| --- | --- |
| Teeth |  |
| Dentures |  |
| Gums |  |
| Identified issues |  |

**Nutrition status**

|  |  |
| --- | --- |
| Weight |  |
| Height |  |
| BMI |  |
| Identified issues |  |

|  |  |
| --- | --- |
| **Dietary needs** |  |
| Identified issues |  |

|  |  |
| --- | --- |
| **Skin integrity** | Normal/Abnormal (sores/lesions)/other |
| Identified issues |  |

**Other medical examination (as relevant)**

|  |  |
| --- | --- |
| Fitness to drive |  |
| Hearing |  |
| Vision |  |
| Smoking |  |
| Foot care |  |
| Sleep |  |
| Cardiovascular risk factors |  |
| Alcohol |  |
| Other identified issues |  |

**A copy of the Comprehensive Medical Assessment must be provided to the Residential Aged Care Facility and offered to the resident.**