

Initial / Annual Proactive Comprehensive Review

Patient's Name and address:

D.O.B.:

Housebound / not housebound (delete as appropriate)

Registered GP and General Practice address

Practice providing Directed Supplementary Service: yes/no

Date of initial / annual assessment(Including (pre morbid) functional (physical and cognitive) baseline):

Screening score:

Rockwood Frailty Scale score: [rockwood_cfs.pdf](#))

If annual review, is there any change from previous year?

Mental State Assessment using recognised tool e.g. Mini-Ace, GPCOG (see local Health Pathway for preferred tool) and record diagnosis where appropriate:

Mini Geriatric Depression Score or 6CIT or similar where relevant would be accepted.

Current Medical Problems:

Systems Review - problems identified

Examination findings

Specific additional areas

Known to Community Services	Receiving social care / district nursing / occupational therapy / physiotherapy etc.	Action required
Mobility	Unaided / stick or Zimmer / wheelchair / bed bound	Action required
Falls assessment	Risk assessment undertaken / required - Yes / No	Action required
Podiatry	Podiatry assessment undertaken / required - Yes / No	Action required
Oral health	Oral health assessment undertaken / required – Yes / No If Yes, is there evidence of a care plan being delivered	Action required

Pressure area review	Yes / No	Action required
Diet	Normal / soft / supplements / PEG Yes / No	Action required
Hearing	Normal / hearing aid / Other problem (please Specify):	Action required
Eyesight	Normal / glasses / Other problem (Please specify): Is there evidence of a care plan being delivered	Action required
Osteoporosis Risk Assessment (Using local agreed clinical pathway and please note most in this age group will not need a DEXA)	Hx of recent falls: Y / N On calcium & Vit D supplements/N On bisphosphonate: Y	Action required

Investigations Recommended by assessor

Medication Review with polypharmacy, antipsychotic prescribing considerations and other high risk medicines Y / N

Any Recommended actions:

Future Care Planning to complete/review/update as appropriate. A proforma template is attached Annex B.

Summary of further actions and person/s responsible: (e.g. onward referral for hearing test or local MDT).

Name and designation of person completing review:

Date: