

# CARE NEEDS QUESTIONNAIRE

Name: \_\_\_\_\_

<b>Eating and Drinking</b>	Yes	No	Office Use
Does the Applicant:	Please tick		
Need assistance with eating or drinking? If yes please continue:			
Modified drinks?			
Need encouragement to finish meal?			
Leave the table during a meal?			
Please circle if necessary for food to be:    cut up            minced            vitamised            soft			
Any other comments: _____ _____ _____			
<b>Mobility</b>	Yes	No	Office Use
Does the Applicant:	Please tick		
Require any assistance with mobility or transfers? If yes please continue:			
Have a history of falls?			
Able to walk?			
Need a wheelchair?			
Need a walking frame or stick?			
Need help getting in/out of bed or chairs?			
Require help when walking?			
Any other comments: _____ _____ _____			
<b>Personal Hygiene</b>	Yes	No	Office Use
Does the Applicant:	Please tick		
Require assistance with washing and dressing? If yes please continue:			
Require assistance with showering and washing?			
Require assistance with dressing and undressing?			
Require assistance with washing & combing hair?			
Require assistance with shaving?			
Require assistance with dental care?			

Any other comments:

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<b>Toileting</b>	Yes	No	Office Use
Does the Applicant:	Please tick		
Need assistance with toileting? If yes please continue:			
Require assistance with sitting on toilet?			
Require assistance with adjusting clothing?			
Require assistance with attending toilet hygiene?			
Any other comments:			
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<b>Bladder &amp; Bowel</b>	Yes	No	Office Use
Does the Applicant:	Please tick		
Bladder – Urinary Loss/leakage? If yes, how often: _____			
Require a catheter?			
Bowel –Loss/leakage? If yes, how often: _____			
Have a colostomy?			
Wear or would benefit from wearing a continence aid			
Any other comments:			
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<b>Behaviours</b>	Yes	No	Office Use
Does the Applicant:	Please tick		
Wander?			
Verbal – aggressive/resistive?			
Physical – aggressive/resistive?			
Any other comments:			
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<b>Cognition</b>	Yes	No	Office Use
Does the Applicant:	Please tick		
Drive a car?			
Is Dementia diagnosed?			
Have any issues with memory loss of confusion?			

Any other comments:

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**Depression**

Does the Applicant:	Yes	No	Office Use
Have issues with memory?			
Is Depression diagnosed?			

Any other comments:

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**Medications**

Does the Applicant:	Yes	No	Office Use
Take any tablets, eye drops or puffers? If yes please continue:			
Require assistance with medications?			
How much time does it take to administer tablets/eye drops/puffers and any other?			
Require assistance with washing & combing hair?			
Require assistance with shaving?			
Require assistance with dental care?			

How much time does it take to administer tablets/eye drops/puffers and any other comments:  
Please circle one of the following:

0-11 minutes

12-22 minutes

23+ minutes

**Other Health**

Does the Applicant:	Yes	No	Office Use
Have daily blood sugar levels taken? If yes please continue:			
Have chronic wound or skin condition?			
Have blood pressure checked often?			
Have trouble with swelling of the feet and ankles?			
Experience much pain?			

Any other comments:

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What is your motivation for applying to move to an aged care facility?

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