COMPREHENSIVE MEDICAL ASSESSMENT
SAMPLE FORM

Use of a specific form to record the results of the CMA is not mandatory but the CMA should cover the matters listed below. The first page of this form can be used as a summary of the CMA.

Resident's Surname: _____	**Other names: _____**
Resident's details (may be available from aged care home) eg Date of Birth: / / Pension No.	Medicare No. DVA No. New or existing resident:
Aged Care Home:	Phone:
Next of Kin/Guardian Name: _____**Phone:**_____	**Advance care directive (or similar?)** ☐No ☐Yes **Enduring Medical Power of Attorney:** ☐No ☐Yes
Has the resident had a previous CMA? ☐ No ☐ Yes, if yes: **Date of last CMA**: / /	**Resident consent** Consent for a CMA obtained? ☐Yes Consent given by Resident ☐ Representative ☐ **Date consent was given:** / /
CMA Service Details Provided by Dr _____Phone:_____ Is this the resident's usual doctor? ☐Yes ☐No **Date/s of service:**	If doctor providing CMA is not the resident's usual doctor, has a report of the CMA been provided to the resident's usual doctor? ☐ Yes ☐ No

DIAGNOSES/PROBLEMS

Principal diagnoses | *Other significant health problems*

IMMEDIATE ACTION

Cardiovascular system		Oral health	
Respiratory system		Nutrition status	
Pain		Dietary needs	
Physical function		Skin integrity	
Psychological function		Continence	

Other:

ALLERGIES AND DRUG INTOLERANCE

CURRENT MEDICATION (including prescribed and non-prescribed medication) *(drug chart/ Webster sheet can be attached)*

Issues for consideration in medication management review:

OTHER SERVICES REQUIRED

EPC Care Plan	Y ☐ N ☐		*EPC Case Conference*	Y ☐ N ☐		*Medication Management Review*	Y ☐ N ☐	

Other:

Comments:

GP's Signature:		Date	/ /

COMPREHENSIVE MEDICAL ASSESSMENT
SAMPLE FORM

RESIDENT'S RELEVANT MEDICAL HISTORY

(May refer to current information from nursing home; information from resident's records can be attached)

IMMUNISATION STATUS

Influenza	Current	Yes ☐	No ☐
Tetanus	Current	Yes ☐	No ☐
Pneumococcus	Current	Yes ☐	No ☐

COMPREHENSIVE MEDICAL EXAMINATION

Cardiovascular system Normal ☐ Abnormal ☐

Identified problems:

Respiratory system Normal ☐ Abnormal ☐

Identified problems:

Pain: Acute No ☐ Yes ☐ **Chronic** No ☐ Yes ☐

If yes, cause of pain:

Physical Function including activities of daily living, eg walking, eating, dressing, personal care (bathing, toilet) **- Identified problems:**

Psychological Function

Mood Normal ☐ Depressed ☐ Other ☐

Cognition Normal ☐ Impaired ☐ Test or screening tool used (eg MMSE) ☐

Identified problems:

COMPREHENSIVE MEDICAL ASSESSMENT
SAMPLE FORM

Oral Health: Teeth ☐ Dentures ☐ Gums ☐
Identified problems:

Nutrition Status: Weight _____ Height ___ BMI _____
Identified problems:

Dietary Needs: **Identified problems:**

Skin Integrity: Normal ☐ Abnormal (sores/lesions) ☐ Other ☐

Identified problems:

Continence: **Urinary** Normal ☐ Abnormal ☐ **Urine Test (if indicated)** Normal ☐ Abnormal ☐
Faecal Normal ☐ Abnormal ☐

Identified problems:

OTHER MEDICAL EXAMINATION AS RELEVANT TO RESIDENT

eg
Fitness to drive
Hearing
Vision
Smoking
Foot care
Sleep
Cardiovascular risk factors
Alcohol use
Other:

Identified problems: