COMPREHENSIVE ASSESSMENT FOR THE SURROGATE DECISION MAKER

Date(s) on which initial assessment was completed_____

Person's Name _____ Phone # _____/_____-_____

Address _____

Date of Birth _____/_____/_____ Social Security # _____/_____/_____

Marital Status ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Single

FAVORITE ACTIVITIES

What are the person's favorite colors?_____

Favorite foods?_____

Favorite T.V. shows?_____

What activities are important to the person (e.g. children, hobbies, religion, etc)?

_____

How does the person feel about what he/she has accomplished in life?_____

_____

What are the person's hopes and goals?_____

_____

What does the person fear most?_____

_____

INTERPERSONAL RELATIONSHIPS

Describe the person's relationship with his/her family_____

_____

Describe the person's relationship with his/her friends_____

_____

Describe the person's relationship with his/her caregivers_____

_____

What important interpersonal issues is the person dealing with at this time?_____

_____

_____

LIVING ARRANGEMENTS

Does the person live ( ) in a house ( ) in an apartment If apartment, what is the landlord's name and telephone number _____

Does the person live alone ( ) yes ( ) no If no, with whom _____

What is this individual's age, health and relationship to the person you will care/are caring for?_____

SUPPORT NETWORKS

If the person has children, list them below and indicate frequency of contact.

Name	Age	Telephone	Address	Frequency of Contact
_____	_____	_____	_____	_____/____
_____	_____	_____	_____	_____/____
_____	_____	_____	_____	_____/____
_____	_____	_____	_____	_____/____

If the person has other relatives, list them below and indicate frequency of contact.

Name	Age	Telephone	Address	Frequency of Contact
_____	_____	_____	_____	_____/____
_____	_____	_____	_____	_____/____
_____	_____	_____	_____	_____/____
_____	_____	_____	_____	_____/____

If anyone regularly provides personal care or does chores for the person, list below

Name	Age	Telephone	Relation to Person	Care Provided
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

CIRCLE THE INDIVIDUAL LISTED IN EACH CATEGORY ABOVE WHO IS THE MOST DEPENDABLE.

Is there any other non-professional the person sees at least once a week._____

_____

If the person has a religious affiliation, list faith/congregation and name and telephone of contact person._____

_____

Are there professionals (e.g., nurses, social worker, therapists, etc.) who regularly provide care to the person

Agency	Telephone	Address	Service
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LEGAL STATUS

Does the person have a GUARDIAN OVER HIS/HER ESTATE ONLY? ( ) yes ( ) no

If yes, are you the guardian of the estate only? ( ) yes ( ) no
If no, complete the following for the guardian of the estate only

Name _____ Phone # _____

Address_____

Does the person have a GUARDIAN OF BOTH HIS/HER PERSON AND ESTATE? ( ) yes ( ) no

If yes, are you the plenary guardian? ( ) yes ( ) no
If no, complete the following for the plenary guardian

Name _____ Phone # _____

Address_____

Does the person have a REPRESENTATIVE PAYEE? ( ) yes ( ) no

If yes, are you the representative payee? ( ) yes ( ) no
If no, complete the following for the representative payee

Name _____ Phone # _____

Address_____

Has the person granted a DURABLE POWER OF ATTORNEY FOR HEALTH CARE and/or a DURABLE POWER OF ATTORNEY FOR PROPERTY? ( ) yes ( ) no

If yes to either or both, what are the powers granted

_____

_____

_____

Under what conditions is the power of the attorney activated?

_____

_____

Is the (durable) power of attorney in force now? ( ) yes ( ) no

Are you the person granted (durable) power of attorney? ( ) yes ( ) no
If no, complete the following for the (durable) power of attorney

Name _____ Phone # _____

Address_____

DAILY LIVING SKILLS

Check any of the following with which the person regularly experiences difficulty

___ Lifting	___ Climbing	___ Hearing
___ Kneeling	___ Balancing	___ Speaking
___ Bending	___ Reaching	___ Reading
___ Walking	___ Seeing	___ Writing
		___ Memory

Other _____

If there are stairs, can the person climb them without resting ( ) yes ( ) no

Does the person drive? ( ) yes ( ) no Is he/she safe driving? ( ) yes ( ) no

Does the person have any problems taking public transportation ( ) yes ( ) no

If yes, describe_____

Is the person uncomfortable traveling in the surrounding area? ( ) yes ( ) no

_____

Does the person do his/her own shopping? ( ) yes ( ) no If yes, how:

( ) walk ( ) taxi ( ) public transit ( ) delivery ( ) gets driven ( ) own car

Does the person eat regularly? ( ) yes ( ) no

Does someone else cook for the person ( ) yes ( ) no

If yes, what is name and telephone_____

Does his/her diet seem to be nutritious and enjoyable? ( ) yes ( ) no

Can the person do all the necessary housework? ( ) yes ( ) no

If no, what needs to be done by someone else?_____

_____

Is someone else available to do this ( ) yes ( ) no

If yes, what is name and telephone_____

Does the home seem to be safe and in reasonable repair ( ) yes ( ) no

If no, what safety improvements or repairs are needed_____

_____

Does the person go out of the house? ( ) yes ( ) no

If yes, how often and for what_____

_____

Does the person own (a) pet(s) ( ) yes ( ) no

If yes, how many, what kind, who cares for them_____

_____

Describe the person's typical day_____

_____

_____

_____

ECONOMIC RESOURCES

Is the person employed? ( ) yes ( ) no

If yes, what is name and telephone_____

_____

Real Estate (List location, value and form of ownership)_____

_____

_____

Check all applicable sources of income and the monthly amount.

___ Social Security Disability $_____.__ / month

___ Social Security Retirement $_____.__ / month

___ Supplemental Security Income (SSI) $_____.__ / month

___ Veterans Administration Benefit $_____.__ / month

___ Private Pension $_____.__ / month

___ Insurance/Annuity $_____.__ / month

___ Trust $_____.__ / month

___ Employment $_____.__ / month

___ Investments (e.g. stocks, bonds, money market) List separately

_____ Purchase cost $_____.__ $_____.__ / month

_____ Purchase cost $_____.__ $_____.__ / month

_____ Purchase cost $_____.__ $_____.__ / month

_____ Purchase cost $_____.__ $_____.__ / month

___ Other (describe)_____ $_____.__ / month

Bank Accounts	Telephone	Account #	Value

Term or Whole Life Insurance	Cash Surrender Value (CSV)	Policy Value (PV)	Beneficiary

Does the person have a safety deposit box? ( ) yes ( ) no

If yes, where is box, its number, where is key_____

Does the person have prepaid funeral arrangements? ( ) yes ( ) no

If yes, name and telephone of funeral home_____

Does the person own (a) burial plot(s)?_____

Does the person own a car?_____

Does the person have other significant assets or financial arrangements? (describe)

_____

_____

Check off all applicable sources of debt and the monthly amount.

___ Mortgage $_____.__ / month

___ Rent $_____.__ / month

___ Property Taxes $_____.__ / month

___ Car Loan Total Amount Owed $_____.__ $_____.__ / month

___ Other Loan Total Amount Owed $_____.__ $_____.__ / month

___ Utilities (e.g. water, gas, electricity, phone) $_____.__ / month

___ Health/Long-Term Care Insurance $_____.__ / month

___ Life/Disability Insurance $_____.__ / month

___ Home/Homeowner Insurance $_____.__ / month

___ Car Insurance $_____.__ / month

___ Medical Bills $_____.__ / month

___ Child Support/Alimony Payments $_____.__ / month

___ Other (describe)_____ $_____.__ / month

Credit Cards	Account Number	Balance Owed	Monthly Payment
_____	_____	$_____.____	$_____.____/mo.
_____	_____	$_____.____	$_____.____/mo.
_____	_____	$_____.____	$_____.____/mo.
_____	_____	$_____.____	$_____.____/mo.

Does the persons receive ( ) Medicare Part A ( ) Medicare Part B ( ) Medicaid

Does the person pay bills in person or by mail?_____

Are the person's income checks deposited automatically? ( ) yes ( ) no

Does the person have checking accounts? ( ) yes ( ) no

Is/are the account(s) in balance? ( ) yes ( ) no

Does someone else assist the person with financial matters? ( ) yes ( ) no

If yes, complete the following for the financial assistant

Name _____ Phone # _____

Address _____

When was the last IRS tax form filed? _____

Does the person understand the business mail that he/she receives? ( ) yes ( ) no

MEDICAL INFORMATION

List all medical practitioners being seen by the person on a regular basis.

Practitioner	Telephone	Specialty

Are all of the medical practitioners aware of one anothers' treatments and prescriptions? ( ) yes ( ) no

Are medical release/consent forms completed for each practitioner and each treatment? ( ) yes ( ) no

List the medical conditions, if any, the person suffers from.

Condition	Date Diagnosed	Effects

Does the person smoke? ( ) yes ( ) no If yes, what and how much _____

If yes, are there dangers of fire from the person's smoking habits? ( ) yes ( ) no

Does the person drink alcohol? ( ) yes ( ) no If yes, how much_____

Does the person abuse drugs or use illegal drugs? ( ) yes ( ) no If yes, what___

_____

Does the person have seizures, dizziness, nausea, black outs ( ) yes ( ) no

If yes, describe_____

List all prescription and over the counter drugs taken by the person.

Name of Drug	Dosage on Label	Who Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are these drugs self-administered ( ) yes ( ) no If no, explain_____

_____

Does the person forget to take medication(s)? ( ) yes ( ) no

What side effects, if any, does the person notice?_____

_____

Does the person experience periods of forgetfulness or confusion? ( ) yes ( ) no

If yes, explain, including times of day or days of week that seem to be better or worse than usual_____

_____

_____

Has a physician or pharmacist examined all the drugs being taken by the person at this time ( ) yes ( ) no

If the person was hospitalized in the last three years, list hospital, admission date, length of stay and treatment_____

_____

_____

Have the medical practitioners made any predictions about the continued ability of the person to

think clearly_____

manage at home_____

Does the person trust his/her medical practitioners? ( ) yes ( ) no

Is there a living will? ( ) yes ( ) no

If the person has expressed in writing his/her wishes regarding the following procedures, list the information requested

	Date Written	Document Location	Expressed Wishes
Organ donation	_____	_____	_____
Kidney dialysis	_____	_____	_____
Resuscitation/CPR	_____	_____	_____
Respirators	_____	_____	_____
Tube feeding/artificial nutrition	_____	_____	_____

What, if anything, has the person expressed verbally about his/her wishes with regard to these procedures?_____

_____

FEELINGS ABOUT ILLNESS, SUFFERING, DYING

What meaning does the person ascribe to his/her illness?_____

_____

What does the person fear most about his/her illness or condition?_____

_____

What does the person think and feel about dying?_____

_____

Does the person have a belief in an afterlife, some kind of continued existence?

_____

_____

What wishes has the person made known regarding arrangements after his/her death?

_____

_____