ARMED FORCES RETIREMENT HOME

Functional Assessment

This assessment is required for all applicants seeking admission to the Armed Forces Retirement Home and must be completed and signed by a licensed Occupational or Physical Therapist. Please answer the following questions based on your professional judgement, observation and functional tests administered during the applicant's visit. Answers are subject to verification for accuracy purposes and all "Yes" answers need to be explained. "Yes" answers may or may not affect your application approval.

Applicant Name: ____
Last Name First Name Middle Initial

Activities of Daily Living (ADL)

1. Requires and/or receives assistance using the phone? (such as: Dialling, receiving, calling 911)

Yes ☐ No ☐

If yes, explain: ____

____

2. Requires and/or receives assistance traveling? (such as: Planning, driving, bus, plane, taxi usage)

Yes ☐ No ☐

If yes, explain: ____

____

3. Requires and/or receives assistance on incline, decline or curbs?

Yes ☐ No ☐

If yes, explain: ____

____

4. Requires and/or receives assistance shopping? (such as: Clothes, hygiene, grooming products)

Yes ☐ No ☐

If yes, explain: ____

____

5. Requires and/or receives assistance to recall current events, locations, dates, names?

Yes ☐ No ☐

If yes, explain: ____

____

Applicant Name: ____
Last Name First Name Middle Initial

6. Requires and/or receives assistance with the preparation and intake of medications?

Yes ☐ No ☐

If yes, explain: ____

____

7. Requires and/or receives assistance with meals: (ie. Feeding, carrying tray, diet)

Yes ☐ No ☐

If yes, explain: ____

____

Specific needs (adaptive equipment): ____

8. Requires and/or receives assistance with maintaining/cleaning living quarters and personal laundry?(such as: Sweeping/vacuuming, making bed, cleaning bathroom, washing garments)

Yes ☐ No ☐

If yes, explain: ____

____

9. Requires and/or receives assistance with personal hygiene? (such as: Bathing, grooming, dressing)

Yes ☐ No ☐

If yes, explain: ____

____

Specific needs (grab bar, bath stool, supervision, etc): ____

____

10. Requires and/or receives therapy services (to address weight, pain, cognition, ADL, wound care)**?**

Yes ☐ No ☐

If yes, explain: ____

____

11. Requires and/or receives assistance of a mobility device? (such as: Wheelchair, person, cane, walker, etc)

Yes ☐ No ☐

If yes, specify type: ____

____

Applicant Name: ____
Last Name First Name Middle Initial

12. Requires and/or receives assistance with toileting? (i.e. Transfer, removing/re-applying clothes)

Yes ☐ No ☐

If yes, explain: ____

____

Specific needs (colostomy, ileostomy, catheter, raised seat, grab bar, bed pan, incontinent supplies, etc):

____

13. Requires and/or receives assistance with transfers? (from chair, bed, bath, vehicle, etc.)

Yes ☐ No ☐

If yes, explain: ____

____

Specific needs (mechanical device, grab bars, lift system, etc.) ______________________

____

14. Requires and/or receives assistance for daily decision making? (such as: Cues, supervision)

Yes ☐ No ☐

If yes, explain: ____

____

15. The individual currently lives or has lived in the past 6 months? (Check all that apply)

☐ Alone
☐ With Family Member
☐ With Caretaker
☐ Assisted Living Facility
☐ Nursing Home
☐ Senior Housing
☐ Apartment
☐ House
☐ Other: ____________

16. The individual uses the following mobility devices on a daily basis? (Check all that apply

☐ Wheelchair (manual)
☐ Wheelchair/Scooter/ Battery Powered Vehicle (electric)
☐ Cane/ Walker/Crutch
☐ Raised Toilet Seat
☐ Grab Bars
☐ Shower Chair / Bathing Stool
☐ Escort
☐ Recliner Chair that lifts one to their feet
☐ Other: __________

17. Furthest distance walked during this session? (can include resting periods)

☐ 150+ feet
☐ 10-25 feet
☐ 51-149 feet
☐ less than 10 feet
☐ 26-50 feet
☐ Unable to walk

Explain, if needed: ____

Applicant name: ____
Last Name First Name Middle Initial

18. Walking support used during this demonstration? (Check all that apply)

None	Cane/Walker/Crutch	Oxygen/ breathing equipment
Parallel Bars	Prosthesis	1-2 persons assisting
	Seeing-eye Dog	Other: ______________

Assessment Information

19. Who participated in this assessment? (Check all that apply)

Individual	Family Member	Significant Other
Caretaker	Friend	Other: ____________

Your signature indicates that you have assessed this individual and the answers to the questions are accurate based on your professional judgement.

____ ______________________________
Signature of Occupational/ Physical Therapist (sign on above line) **Print Name**

___________________________ ____________________________
License Number/State Date Assessment Completed

Telephone Number: ____

Email Address: ____

Return to:
Armed Forces Retirement Home
Public Affairs Office #1305
3700 North Capitol Street, NW
Washington, DC 20011-8400
Fax Number: (202) 541-7519