



Comprehensive Medical Assessment (CMA) for Residents of Aged Care Facilities (Item 712)

MBS Item 712

Use of a specific form to record the results of the health assessment is not mandatory but the health assessment should cover the matters listed in the Explanatory Notes for the health check in the Medicare Benefits Schedule Book. The first pages of this form can be used as a summary of the health assessment.

This check list must be read in conjunction with the explanatory notes for Item 712 (as set out in the Medicare Benefits Schedule Book).

Resident Details

Resident's Name
.....

Male Female

DOB/...../..... or Age

Current contact details

Residential Aged Care Facility (RACF)
.....

Consultation with carer? Yes No

Phone

Carer's name/s

Pension No

Address

Phone

Next of kin/guardian

Name

Power of attorney (recommended)

Phone

Advance Care Directive (or similar)? Yes No

Enduring Medical Power of Attorney? Yes No

New or existing resident (mandatory)

Is the resident a new or existing resident?

Previous CMA (recommended)

New Existing

Has the resident had a previous CMA?

Yes No

If existing resident, reason for CMA

If yes, when/...../.....

.....

Service provided by Dr.

Resident Consent (mandatory)

Explanation of CMA given? Yes

Consent given for information to be collected by:

Consent for CMA given? Yes

Nurse Yes No

Consent given by? Resident Carer

Other health professional Yes No

Date consent was given/...../.....

If yes, please specify

.....



DETAILED MEDICAL HISTORY (mandatory)

**RESULTS OF RELEVANT PREVIOUS ASSESSMENTS
(eg. GPs, specialists and/or community based assessments)**

.....
.....
.....
.....
.....

RESULTS OF RELEVANT PREVIOUS INVESTIGATIONS AND ALLIED HEALTH INTERVENTIONS

.....
.....
.....
.....

RESULTS OF ASSESSMENT AND INTERVENTION BY NURSING STAFF OF THE RACF

.....
.....
.....
.....

DETAILS OF ALLERGIES AND ANY DRUG INTOLERANCE

.....
.....
.....
.....

RESIDENT'S CURRENT MEDICATION (including prescribed and non-prescribed medication – drug chart/Weber sheet can be attached)

.....
.....
.....
.....

ACUTE AND CHRONIC PAIN

.....
.....
.....
.....

FALLS IN THE LAST THREE MONTHS

.....
.....
.....
.....



IMMUNISATION STATUS

Influenza	Current	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Tetanus	Current	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Pneumococcus	Current	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

CONTINENCE

Urinary	Normal	<input type="checkbox"/>	Abnormal	<input type="checkbox"/>
Urine Test (as indicated)	Normal	<input type="checkbox"/>	Abnormal	<input type="checkbox"/>
Faecal	Normal	<input type="checkbox"/>	Abnormal	<input type="checkbox"/>

Identified issues

.....

.....

.....

.....

FACTORS LEADING TO ADMISSION INTO THE RACF

.....

.....

.....

.....

.....

COMPREHENSIVE MEDICAL EXAMINATION (mandatory)

Cardiovascular system Normal Abnormal

Identified issues:

.....

.....

.....

.....

Respiratory system Normal Abnormal

Identified issues:

.....

.....

.....

.....

Pain *Acute* Yes No *Chronic* Yes No

If yes, cause of pain:

.....

.....

.....

.....



Physical function (including activities of daily living, e.g. walking, eating, dressing, personal care – bathing)

Identified issues:

.....
.....
.....
.....

Psychological function

Mood Normal Depressed Other

Cognition Normal Impaired Test or screening tool used (e.g. MMSE)

Identified issues

.....
.....
.....
.....

Oral health Teeth Dentures Gums

Identified issues

.....
.....
.....
.....

Nutritional status Weight Height BMI

Identified issues

.....
.....
.....
.....

Dietary needs

Identified issues

.....
.....
.....
.....

Skin integrity Normal Abnormal (sores/lesions) Other

Identified issues

.....
.....
.....
.....



OTHER MEDICAL EXAMINATION (as relevant)

For example

- Fitness to drive
- Hearing
- Vision
- Smoking
- Foot care
- Sleep
- Cardiovascular risk factors
- Alcohol use

Identified issues

.....

.....

.....

.....

DIAGNOSIS/HEALTH ISSUES

.....

.....

.....

IMMEDIATE ACTION REQUIRED

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

OTHER SERVICES REQUIRED

EPC Care Plan Yes No EPC Case Conference Yes No

Medication Management Review Yes No

Other

.....

.....

.....

.....

Next medical review due: Date/...../.....

GP Dr. GP's signature Date/...../.....

A copy of the Comprehensive Medical Assessment must be provided to the Residential Aged Care Facility and offered to the resident.