



# Summary of Assessment

## CONFIDENTIAL

Physician to photocopy blank form, complete and fax to the Designated Responder when further inquiry or possible protection of a vulnerable adult is indicated. Place copy on patient chart in office and on hospital/residence chart where applicable. Contact 1-877-REACT-99 if you require further direction on where to refer.

<b>Adult/Patient Name:</b> _____	<b>DOB:</b> _____	<b>PHN:</b> _____
<b>Address:</b> _____	<b>Phone:</b> _____	
<b>Family Member/Caregiver:</b> _____	<b>Phone:</b> _____	

### A. Summary of Suspected Abuse, Neglect or Self-Neglect: (observed or reported by adult/other)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Physical Assault | <input type="checkbox"/> Physical Restraint | <input type="checkbox"/> Sexual Assault                |
| <input type="checkbox"/> Neglect          | <input type="checkbox"/> Self-Neglect       | <input type="checkbox"/> Psychological/Emotional Abuse |
| <input type="checkbox"/> Theft            | <input type="checkbox"/> Financial Abuse    | <input type="checkbox"/> Intimidation/Threats          |
| <input type="checkbox"/> Fraud            | <input type="checkbox"/> Breach of Trust    | <input type="checkbox"/> Misuse of a Power of Attorney |
| <input type="checkbox"/> Other (specify)  |   |  |

#### Details:

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### B. Summary of Medical Assessment: Include diagnosis and underlying medical, psychiatric or other condition that may affect decision-making ability.

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### C. Summary of Cognitive Function and Executive Dysfunction:

MMSE: \_\_\_\_\_ 3MS: \_\_\_\_\_ Other Screening Tool: \_\_\_\_\_

Comment on reported or observed deterioration in initiating, planning, or performing ADL/IADL's:

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Describe insight & judgement: \_\_\_\_\_

### D. Physician Information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

