



# SENIORS ASSESSMENT TOOL

This Assessment Tool pertains to the Guideline:  
*Frailty in Older Adults – Early Identification and Management*  
www.BCGuidelines.ca



NAME OF SENIOR	PERSONAL HEALTH NUMBER	DATE
NAME OF PHARMACY		LOCATION

1. How has your health been since your last visit?  better  same  worse: \_\_\_\_\_

2. Do you have concerns or problems with any of the following:

Medications  No  Yes: \_\_\_\_\_

Pain  No  Yes: \_\_\_\_\_

Falls  No  Yes: \_\_\_\_\_

Decreased energy  No  Yes: \_\_\_\_\_

Nutrition  No  Yes: \_\_\_\_\_

Memory  No  Yes: \_\_\_\_\_

Bladder/Bowels  No  Yes: \_\_\_\_\_

Hearing  No  Yes: \_\_\_\_\_

Vision  No  Yes: \_\_\_\_\_

Sleep  No  Yes: \_\_\_\_\_

Depression/Lonliness  No  Yes: \_\_\_\_\_

Looking after yourself  No  Yes: \_\_\_\_\_

Looking after your home  No  Yes: \_\_\_\_\_

Finances  No  Yes: \_\_\_\_\_

Transport  No  Yes: \_\_\_\_\_

3. Where do you live?  own home  with family  facility  
 other: \_\_\_\_\_

4. Do you live alone?  No  Yes

5. Do you have help in the home?  No  Yes:

6. Do you have a contact for emergencies?  No  Yes

If yes, who could you call?  family friend  neighbour  Lifeline  
 other: \_\_\_\_\_

7. Have you signed a Power of Attorney?  No  Yes

8. Have you made a Will?  No  Yes

9. Do you want to discuss end-of-life plans?  No  Yes

10. Have you signed a "No CPR" form?  No  Yes

11. Would you consider Lifeline quick response?  No  Yes  I have Lifeline (or similar service)