Gilbert Guide Face Sheet

Everything You Need in One Place

The Basics

Full Name:_____ **Date of Birth**: ____/____/____

Nickname (if applicable):_____ **Resident/Patient ID**:_____

Insurance Carrier: _____ **Insurance ID #**:_____

Primary Contact: _____ **Phone Number**: _____

Contact's Relationship to Resident/Patient: _____

Medical History & Current Status

▶ **Current Medical Conditions** (Note any diagnosis along with any medical issues or concerns.)

_____

_____

_____

_____

▶ **Immunity & Immunizations** (Please write the month and year on the line provided.)

☐ Flu Shot____/____ ☐ Pneumonia____/____ ☐ Tetanus____/____

☐ Zostavax ____/____ PPD Status _____as of____/____

Any known allergies? _____

▶ **Previous Medical Conditions** (Note any medical conditions in your past. If applicable note if the condition was resolved by surgery, medication or other means.)

_____

_____

_____

_____

_____

▶ **Previous Hospitalizations** (Please write the month and year on the line provided.)

Reason: _____ **Date**: ____/____

Notes:_____

Reason: _____ **Date**: ____/____

Notes: _____

Reason: _____ **Date**: ____/____

Notes: _____

Reason: _____ **Date**: ____/____

Notes: _____

▶ **Previous Surgeries** (Please write the month and year on the line provided.)

Type: _____ **Date**: ____/____

Notes: _____

Type: _____ **Date**: ____/____

Notes: _____

Type: _____ **Date**: ____/____

Notes: _____

Type: _____ **Date**: ____/____

Notes: _____

Functioning

❖ APPEARANCE

(For the following questions, if an assistive device or prosthetic is working and causes any diminished capacity to be normal, mark it as "good.")

Communication	☐ *Good*	☐ *Fair*	☐ *Needs Attention* _____
Dental Health	☐ *Good*	☐ *Fair*	☐ *Needs Attention* _____
Feet	☐ *Good*	☐ *Fair*	☐ *Needs Attention* _____
Hearing	☐ *Good*	☐ *Fair*	☐ *Needs Attention* _____
Vision	☐ *Good*	☐ *Fair*	☐ *Needs Attention* _____
Skin Condition	☐ *Good*	☐ *Fair*	☐ *Needs Attention* _____

❖ ACTIVITIES OF DAILY LIVING (ADL)

Bathing	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Dressing	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Grooming	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Eating	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Transfers	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Ambulation	☐ *Independent*	☐ *Assistive device (cane/wheelchair)*	☐ *Cannot Ambulate*

❖ CONTINENCE

Urine	☐ *Continent*	☐ *Incontinent*	☐ *Occasionally Incontinent*
Stool	☐ *Continent*	☐ *Incontinent*	☐ *Occasionally Incontinent*
Catheter	☐ *Yes*		

❖ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Preparing Meals	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Arranging Travel	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Climbing stairs	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Housekeeping	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Shopping	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Walking outdoors	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Managing Finances	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*
Managing Meds	☐ *Independent*	☐ *Needs Some Assistance*	☐ *Dependent*

Finding & Utilizing Resources (e.g., making and keeping doctors appointments)
☐ *Independent* ☐ *Needs Some Assistance* ☐ *Dependent*

Socializing with others (makes plans, talks to friends or family regularly)
☐ *Very Social* ☐ *Needs Some Nudging* ☐ *Does Not Try/Want to*

❖ PSYCHIATRIC & BEHAVIORAL

Any Psychiatric Diagnosis? _____

Behavioral Issues: _____

Mental Status Exam: ☐ *MMSE* ☐ *SLUMS* ☐ *Other* _____

Scoring _____/_____; Date _____/_____ Scoring _____/_____; Date _____/_____

Personal

Dietary Preferences: _____
Religious Affiliation: _____
Notes on Customary Daily Routine: _____
Things to Know (likes/dislikes, pet peeves): _____
_____

Patient Wishes & Protocols

☐ Durable Power of Attorney
Name & Contact Details: _____
☐ Medical Power of Attorney or Healthcare Proxy
Name & Contact Details: _____
☐ Advanced directives
Contact person and phone numbers _____

☐ DNR	☐ No Antibiotics	☐ No IVs
☐ No Feeding Tube	☐ Do Not Hospitalize	☐ Only Comfort Care