



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.

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

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:

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

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:

Describe insight & judgement: _____

D. Physician Information:

Name: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

