|  |  |  |  |
| --- | --- | --- | --- |
| **一宮市地域連携**  **アセスメントシート** | 下記利用者(家族)の同意に基づき、利用者の身体・生活機能等の情報を提供します。 | | |
| **情報提供先**  **医療機関名** |  | 年     月     日 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **基本情報** | ふりがな | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 男  ・  女 | | | | 〒 | | | | |  | | | | | － | |  | | | | | | | | |
| 利用者氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| 生年月日 | | | | |  | | | | | | 年 | | | |  | | | | | 月 | | | | | |  | | | | 日 ( | | | | | | | |  | | | | | 歳) | | | | | | TEL： | | | | | | |  | | | | | | | | | | | | | |
| 住環境 | | | | | 戸建 | | | | ｱﾊﾟｰﾄ･ﾏﾝｼｮﾝ ( | | | | | | | | | | | | | | |  | | | | | 階) | | エレベーター | | | | | | | | | | | | | | | | | | | | 施設 ( | | | | | | | | | | | | | | | | | | | | | ) | |
| 障害等認定 | | | | | 無 | | | | 身障 ( | | | | | | |  | | | 級) | | | | | | 精神 ( | | | | | | | | |  | | | 級) | | | | | 療育 | | | | | | | | | 特定疾患 ( | | | | | | | | | | | | | | | | | | | | | ) | |
| 要介護認定 | | | | | 無 | | | | 要支援 ( | | | | | | | |  | | | | ) | | | | 要介護 ( | | | | | | | | | | | | |  | ) | | | 申請中 | | | | | | | | | | 有効      年   月   日～     年   月   日 | | | | | | | | | | | | | | | | | | | | | |
| 経済状況 | | | | | 年金 ( | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ) | | | 生活保護 他 ( | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ) | |
| 趣味性格 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | 生活歴 | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | |
| **家族** | 連絡先 | | | 氏名： | | | | | | | | | | | | | | | 続柄 ( | | | | | | | | |  | | | | | )　TEL： | | | | | | | | | | | | | | | | | | | | | | | | | 家族構成 | | | | | |  | | | | | | | | | | |
| 氏名： | | | | | | | | | | | | | | | 続柄 ( | | | | | | | | |  | | | | | )　TEL： | | | | | | | | | | | | | | | | | | | | | | | | | ◎本人  □男　〇女  ☆キーパーソン  ■●死亡 | | | | | |
| 主  介護 | | | 氏名： | | | | | | | | | | | | | | | 続柄 (　　　　　　) 年齢　　　　　　　歳 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 介護  状況 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **利用サービス** | 医療機関 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (通院・在宅医療） | | | | | | | | | | | | | | | | | | | 薬局 | | | | |  | | | | | | | | | | | |
| 歯科医療機関 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 居宅療養管理指導 | | | | | | | | | | | | | | | | | 職種： | | | | | | | | | | | |
| 介護サービス | | | | | | | | 訪問介護 | | | | | 訪問看護 | | | | | | | | | | | | | | | 訪問入浴 | | | | | | | | | | | | 訪問リハ | | | | | | | | | | | | | | | | | 通所介護 | | | | | | | 通所リハ | | | | | | | 短期入所 | | |
| 自己負担割合  (   割) | | | | | | | |  | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | |  | | |
| 福祉用具 ( | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ) | | | 他 ( | | | | | | | | | | | | | | | | ) |
|  | 疾患歴 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 医療処置　無 | | | | | | | |
| 胃ろう　 経鼻栄養  ＩＶＨ　 インスリン  末梢点滴 気管切開  酸素 (     L) 麻薬  人工呼吸 尿道カテ  人工膀胱 人工肛門  吸痰 (     回／日 )  導尿 (     回／日 ) | | | | | | | |
| 薬情添付あり | お薬情報 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 服薬管理 | | | 自立  見守り  一部介助  全介助 | | | | | | | | | | | | | | 服薬状況 | | | | | 処方通り  飲み忘れ時々  飲み忘れ多い  処方守れない | | | | | | | | | | |
| 入院歴 | | | | 無　有　過去1年間の入院回数 ( | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | 回) | | 直近入院     年     月頃 | | | | | | | | | | | | | | | | | | | | | | |
| アレルギー | | | | | | | 視力支障 | | | | | 褥瘡 | | | | | | | | | | 麻痺 | | | | | | | | | | | | | | | | | | | | | | | | 口腔ケア | | | | | | | | | | | | | 義歯使用 | | | | | | |
| **身体・生活機能** | 無 有 | | | | | | | 無 有 | | | | | 無 有  発赤  びらん  潰瘍 | | | | | | | | | | 無　　　他部位  左上肢　右上肢  左下肢　右下肢  軽度 中度 重度 | | | | | | | | | | | | | | | | | | | | | | | | 自立  見守り  一部介助  全介助 | | | | | | | | | | | | | 良  不良  不使用  義歯不要 | | | | | | | 周辺症状　無 | | | | | | | |
| 感染症 | | | | | | | 聴力支障 | | | | | 失見当識 徘徊  理解力なし せん妄  暴言暴力 大声  うつ傾向 昼夜逆転  介護抵抗 不潔行為 | | | | | | | |
| 無 有 | | | | | | | 無 有 | | | | |
| 医療特記 | |  | | | | | | | | | | | | | | | | | | | | 意思疎通 | | | | | | | | | | | | | | | | | | | | | | | | 睡眠障害 | | | | | | | | | | | | | 嚥下機能 | | | | | | |
| 可 一部可 不可 | | | | | | | | | | | | | | | | | | | | | | | | 無 有 | | | | | | | | | | | | | 良 不良 | | | | | | |
|  | | 移　動 | | | | | 移　乗 | | | | 更　衣 | | | | | | | | | | | | | 入　浴 | | | | | | | | | | | | 食　事 | | | | | | | | | | | | | 食事形態 | | | | | | | | | | | | | 摂取方法 | | | | | | | | | 摂取制限 | | | |
|  | | 自立  見守り  一部介助  全介助 | | | | | 自立  見守り  一部介助  全介助 | | | | 自立  見守り  一部介助  全介助 | | | | | | | | | | | | | 自立  見守り  一部介助  全介助 | | | | | | | | | | | | 自立  見守り  一部介助  全介助 | | | | | | | | | | | | | 普通  きざみ  嚥下食  ミキサー | | | | | | | | | | | | | 経口 経管 | | | | | | | | | 食事 水分 | | | |
| ケアマネジャーが考える 在宅生活に必要な要件 | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 移動手段 | | | | | 起居動作 | | | | 整　容 | | | | | | | | | | | | | 排　尿 | | | | | | | | | | | | 排　便 | | | | | | | | | | | | | 排泄方法 | | | | | | | | | | | | |
| 独歩  杖  歩行器  車いす | | | | | 自立  見守り  一部介助  全介助 | | | | 自立  見守り  一部介助  全介助 | | | | | | | | | | | | | 自立  見守り  一部介助  全介助 | | | | | | | | | | | | 自立  見守り  一部介助  全介助 | | | | | | | | | | | | | トイレ  ポータブル  尿器  おむつ | | | | | | | | | | | | |
| 入院前の本人家族の意向 | | | | | | | | | | | | | | | 入院に至る経過・特記事項 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 記入者 | | | 所属 | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| 氏名 | | | | | | | | |  | | | | | | | | | | | | 職種： | | | | | |
| TEL | | | | | | | | |  | | | | | | | | | | | FAX | |  | | | | |
| 退院前カンファレンスの開催　希望あり | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

一宮市在宅医療・介護連携推進協議会 【ver.4】R5.2