

# THE SEISAR TOOL: Assessment & Intervention

## Standardized Personal Information Form

## ADDRESSOGRAPH

• Residence type: Name/Phone/Fax	
• Primary caregiver(s) Name/Phone	Name/Phone
• Primary care physician Name/Phone/Fax	• Homecare service contact person Name/Phone/Fax

### SEISAR Problem Checklist (please refer to the corresponding standardized questionnaire in annex)

Y	C	N	INT	COMMUNICATION
			MD	Impaired vision
			MD	Impaired hearing

Y	C	N	INT	MEDICATION
			GA/MD	Polypharmacy/new medication
			GA/S	Rx management difficulties

Y	C	N	INT	COGNITION
			ED/S	Acute confusion/disorientation
			GA/S	Undiagnosed cognitive problem

Y	C	N	INT	BEHAVIOR/AFFECT
			GA/S	Depression
			ED/S/GA	Agitation

Y	C	N	INT	NUTRITION
			MD/G/S	Recent weight loss/malnutrition
			MD/S	Substance abuse

Y	C	N	INT	ACTIVE MEDICAL ISSUES
			ED	Persistent presenting symptoms
			MD	Active co morbidities

Y	C	N	INT	MOBILITY
			GA/S	Falls (past or recent)
			GA/S	Problems walking/difficulty in using walking aid

Y	C	N	INT	PAIN MANAGEMENT
			ED/S	Persistent pain
			ED/MD	Joint/bone pain

Y	C	N	INT	ACTIVITES OF DAILY LIVING
			S	Difficulties with meal preparation
			S	Limitations with basic hygiene
			MD/S	Incontinence

Y	C	N	INT	SOCIAL
			S/MD	Insufficient support, lives alone
			S/MD	Social isolation/neglect
			S/MD	Previously refused service

**Y** YES, problem present     
 **C** Problem present but **COMPENSATED**     
 **N** NO, problem absent

**INT**: MD – Primary care physician     
 ED – ED physician     
 S – Homecare service     
 GA – Geriatric assessment

### Standardized Information (Check where appropriate)

Source of information:	Living Arrangements:	Referrals given:
<input type="checkbox"/> Patient	<input type="checkbox"/> Alone	<input type="checkbox"/> GP letter
<input type="checkbox"/> Caregiver	<input type="checkbox"/> With spouse/family	<input type="checkbox"/> Home care
<input type="checkbox"/> Home Care contact	<input type="checkbox"/> Residence with services	<input type="checkbox"/> ED referral
	<input type="checkbox"/> House/apartment	
	<input type="checkbox"/> Group home, nursing home, LTC	
	<input type="checkbox"/> Residence with no services	

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