

Functional Assessment

NAME: _____

Today's date: _____

PHN: _____

1. For each category, please check the one response that best describes your abilities **over the past week**.

HAVE YOU BEEN ABLE TO	With NO Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE to do
Dressing and Grooming				
Dress yourself, including tying shoelaces and doing buttons				
Shampoo your hair				
Rising				
Stand up from an armless chair				
Get in and out of bed				
Eating				
Cut your meat				
Lift a full cup or glass to your mouth				
Open a new carton of milk				
Walking				
Walk outdoors on flat ground				
Climb up five steps				
Hygiene				
Wash and dry your entire body				
Take a bath				
Get on and off the toilet				
Reach				
Reach and get down a 5 lb. object (for example, a bag of sugar from just above your head)				
Bend down to pick up clothing from the floor				
Grip				
Open the car doors				
Open jars which have been previously opened				
Turn taps on and off				
Activities				
Run errands and shop				
Get in and out of a car				
Do chores such as vacuuming, housework or light gardening				

Please continue on page 2...

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2. Do you **usually** (more than 50% of the time) use the following aids or devices for any of the activities listed on page 1?

Aids or devices	YES	NO
Canes		
Walker		
Crutches		
Wheelchair/scooter		
Raised toilet seat		
Bath seat		
Jar opener (for jars previously opened)		
Built-up or special utensils		
Special or built-up chair		
Bath rail		
Long-handled appliances for reach		
Other		

3. Do you **usually** (more than 50% of the time) need help from another person for any of the following?

Task	YES	NO
Errands and housework		
Reaching		
Dressing and grooming		
Gripping and opening things		
Eating		
Walking		
Rising		
Hygiene		

4. Please **circle** the number, from 0 to 10, which indicates how much pain you have had in the past week because of your arthritis, with 0 being "no pain" and 10 being "pain as bad as it could be."

PAIN SCALE RATING 0 1 2 3 4 5 6 7 8 9 10

Patient Consent

Personal information on this form is collected for the operations of the Ministry of Health. The Ministry will use the information in the decision to provide PharmaCare benefits for the medication requested, and for implementation, monitoring and evaluation of this and other Ministry programs, and for the management and planning of the health system generally. Personal information will be used and disclosed in accordance with the privacy protection provisions of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection of this information, call Health Insurance BC at 1-604-683-7151 from Vancouver or, from elsewhere in BC, toll-free at 1-800-663-7100, and ask to consult a pharmacist concerning the Special Authority process.

I authorize the prescriber to release to PharmaCare and the Ministry of Health the information contained in this form and any other related information in the prescriber's custody as required for adjudication, monitoring and evaluation.

PATIENT'S SIGNATURE

DATE
