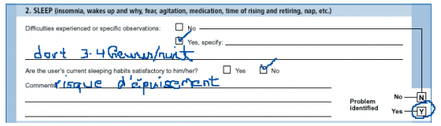
HOW TO COMPLETE

Checklist

- Look for to cover every aspect.
- Describe the problem, if difficulties arise.
- Specify the source of information:
  F:Family or Friend
  U:User
  E:Evaluator.
- Provide grounds for your choice (yes/no) in the comments section where appropriate.



- In case of doubt, it is better to over-estimate rather than under-estimate a disability.

CARE TABLE
Scale of cotation

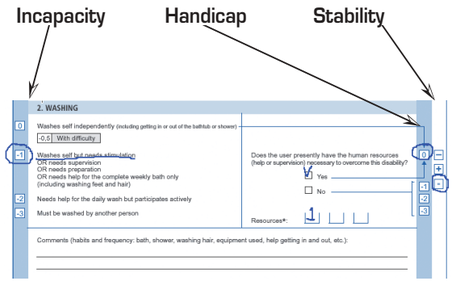
Letter	Color	Level of autonomy	Score
G	Green	Independent	0
T	Turquoise	Independent with difficulty	-0, 5 –1, 5
B	Blue	Supervision/stimulation	-1
Y	Yellow	Some assistance	-2
R	Red	Complete assistance	-3

N.B. Read attentively the definition of each colour on the back of the form.

- Paste the corresponding colour stickers to the user level of autonomy for each function represented by a pictogram.
- Tick the case to identify the complementary particularities.

SMAF

- Encircle the appropriate score in the section " Incapacity ".
- Underline the corresponding item if more than one choice.
- Make sure that the handicap score is the same as the disability score if the situation is not entirely overcome.
- Make sure the handicap score will be " 0 " if the situation is **entirely** overcome whatever the living environment (Home, CHSLD, IR …): a situation is overcome if the user has access to resources of sufficient quality and quantity at the time it is required.
- Identify the stability only if the resources are available. Indicate if the resources will [-] decrease, [+] increase or [.] remain stable in the coming three or four weeks.



- If the number " 7 " is ticked, indicate the type of resource in the comment section.

Access mechanism

- Users must not be assessed or reassessed in an acute phase of illness or in a **crisis** situation. Their rehabilitation must be completed.
- Requests to the regional access mechanism should only be submitted if users are in a stable condition.

Make sure that photocopies of the following forms are sent:

- Intake form (green) with up-to-date information.
- Multiclientele Autonomy Assessment form (blue).
- Evolutive Autonomy Profile form (salmon) with up-to-date information (if first assessment, transcribe information into first column).
- Medical evaluation.
- Consent form.
- Relevant reports (e.g., physiotherapy, occupational therapy, etc.).
- Care Table (if already complete).

Outil d'évaluation multiclientèle (OEMC)

www.msss.gouv.qc.ca/f/documentation/oemc

Functional Autonomy
Measuring System

Formation SMAF sur web CT : *www.iugs.ca*

03-806-02A

HOW TO USE IT

Summary guideline for the utilization of

Multiclientele Assessment Tool

Centre d'expertise de l'Institut universitaire de gériatrie de Sherbrooke

Santé et Services sociaux Québec

GENERAL DESCRIPTION OF MULTICLIENTELE ASSESSMENT TOOL

	Intake (green)	Autonomy Assessment (blue)	Evolutive Autonomy Profile (salmon)	Autonomy Assessment Short-Term Care Clientele (mallow)	Intervention and Service Allocation Plan (pink)
When	■ Registration ■ Preassessment ■ Request for change of living environment	■ Assessment ■ Request for change of living environment ■ Referral of client to another establishment ■ Care management transfer to integrated services network	■ Continuous assessment ■ Reassessment Request for change in living environment	■ Assessment of short-term care clientele (overall notion of state of health)	■ Intervention planning
Target Clientele	■ All target clienteles	■ Clienteles experiencing loss of autonomy, except those requiring short-term interventions or care (includes CLSCs, CHSLDs, RIs, RTF, CHSGSs, CRs)	■ Long-term care clientele in home care or care facility setting	■ Clientele requiring a single type of service for less than 3 months	■ All clienteles experiencing temporary or permanent loss of autonomy ■ Especially clientele receiving services from more than one professional ■ For CHSLDs already using computerized treatment plans, the print version of the OEMC Intervention Plan is not required
Frequency	■ Once per service episode	■ At transfer of care management for clients experiencing loss of autonomy ■ Generally once a year, or upon any major change ■ As part of continuous assessment	■ During review of autonomy assessment (use blue form for revision)	■ Once every care episode	■ Reviewed as required
Fonctions	■ Determine eligibility ■ Establish assessment priority ■ Identify profession most apt to respond to request ■ Or orient to another resource	■ Assess overall needs in view of preparing an intervention plan ■ Identify required services ■ Present case when a change of living environment is requested	■ Record results of autonomy assessment and reassessment ■ Observe any changes in client autonomy	■ Assess overall needs with emphasis on health dimension ■ Identify required services	■ Draw up intervention plan ■ Identify required services
Users (who completes it)	■ Professional in charge of screening or who requests the change in living environment	■ Professional in charge of client services, in cooperation with care and service team ■ Case manager for one-stop assessment of request for change in living environment	■ Professional in charge of client services, in cooperation with care and service team	■ Professional in charge of client services	■ Professional in charge of client services, in cooperation with care and service team
Additional information	*Information not obtained during intake must be added upon subsequent evaluation ("Autonomy Assessment" form)*	*As soon as the autonomy assessment is complete,transcribe the information on the "Evolutive Autonomy Profile" form (salmon)*			

N. B.: The form "Care Table" is a synthesis portrait of the Functional Autonomy Measuring System of the evaluated client. It ensues from the results at the form "Autonomy Assessement".

GENERAL INSTRUCTIONS

- The form should be completed by one person.
- If more than one person is involved for completing the form, the person responsible must initial the sections completed and signed by other contributors and ensure that information is consistent throughout the document.
- Information must be written in pen.
- Whenever possible, use the detailed assessment (blue) rather than the short-term assessment (mallow), this last form is required for a specific service or care on a short-term basis.
- Before completing a section, read the description of each item carefully.
- When recording information, remember that other people will be using the assessment to determine their course of action.
- All sections must be completed. Write " no information collected " or " information unavailable ", along with " incomplete assessment ". Do not write " N/A " or " N/E " and do not leave blank spaces. Use a slash or vertical line to show that content has been completed and indicate that you have evaluated all the items.
- Use only recognized abbreviations.