Geriatric Outpatient Assessment and Treatment Plan

Note: This document is formatted for clinical record-keeping and printing. Please fill out all applicable text fields.

1. Patient Information

Patient Full Name:		Date of Birth:	MM/DD/YYYY
Medical Record Number (MRN):		Assessment Date:	MM/DD/YYYY
Primary Caregiver / Relation:		Caregiver Contact:	

2. Cognitive and Mental Health Status

Cognitive Screen (e.g., Mini-Cog, MoCA score and notes):

Depression Screen (e.g., PHQ-9 score and notes):

Behavioral/Psychiatric Symptoms:

3. Functional Status & Mobility

Specify level of independence (e.g., Independent, Assisted, Dependent)

Bathing / Dressing:		Toileting:	
Feeding:		Transferring:	
Medication Management:		Financial Management:	

Mobility Aid / Assistive Devices (e.g., Cane, Walker, None):

Fall History (Number of falls in past 12 months, injuries):

4. Sensory and Nutrition Assessment

Sensory Impairments (Hearing / Vision status):

Nutritional Status & Appetite (Recent weight changes):

5. Medication Review & Safety

Identify high-risk medications (Beers Criteria), polypharmacy concerns, or adherence issues.

Medication Review Notes:

6. Treatment Plan & Interventions

Medical Management / Chronic Conditions Plan:

Physical / Occupational Therapy Interventions:

Social Support & Community Resources (e.g., Home health, Day program):

Home Safety / Fall Prevention Plan:

7. Follow-Up and Sign-Off

Follow-Up Schedule:	
Provider Name / Credentials:	
Provider Signature:	Sign on printed copy