

FACILITY NAME: _____

RESIDENT ASSESSMENT

Admission Assessment _____

Annual Assessment _____

DEMOGRAPHIC/SOCIAL INFORMATION				Section
1 (This section to be completed by facility)				
Resident's Name		Nickname		
Address (Pre admission)		DOB		
		SEX	M F	
Admission From: (circle one & identify)	Home Hospital:	Other:		
Language Spoken		Marital Status	M D W S	
Resident's Former Occupation		Religious Preference		
Resident's Hobbies/Interests				
Responsible Party Legal Representative		Phone Number		
Address				
Relationship (Circle all that apply)	Spouse Child Sibling	Other _____	Guardian Committee	
Other Care Providers (Dentist, Podiatrist, etc)				

MEDICAL/HEALTH ASSESSMENT		Section
2		
Admission Diagnosis		
Allergies		
Medical Assessment		
Date Completed		
Skin Condition		
Skin Breakdown		
Decubitus (Size, Location, Treatment)		
Diet	Activity	

Other Services and Treatment Orders (Oxygen, PT, OT, Home Health, Hospice, etc)		
Current Medications (including over the counter)		
Is Resident Capable of Administering Own Medications? (Must be able to read and understand medication labels and meds taken)	Y	N
TB Screening (Date and Results)		
Previous Positive-give presence or Absence of symptoms		
Can services be met in Assisted Living or Residential Care Community	Y	N
Resident Requires Sleep Time Supervision (Facility Must Have Awake Staff)	Y	N
Advance Directive	Y	N

FUNCTIONAL LEVEL						Section
					3	
Sight	Not Impaired		Impaired		Blind	
Hearing	Not Impaired		Impaired		Deaf	
Speech	Not Impaired		Impaired		Aphasic	

ACTIVITIES OF DAILY LIVING

	Self	With Assistance		Total Assist		
Eating						
Bathing						
Dressing						
Toileting						
Urinary	Continent		Incontinent		Catheter	
Bowel	Continent		Incontinent		Colostomy	
Mobility	Ambulatory		Cane/Walker		Wheelchair	Bedfast
Mobility Assistance		1 person		2 person	Total Assist	

PSYCHOSOCIAL/BEHAVIORIAL LEVEL

Section 4

	Never	Occasionally	Frequently	Comments
Wanders				
Noisy				
Disoriented				
Displays inappropriate behavior (Identify behavior)				
Withdrawn/Depressed				
Combative				
Delusional				
Impaired Judgment (explain)				
Outside Services (Agency)				

To the best of my knowledge, the patient's medical, functional level and psychosocial needs are as indicated above.

Physician's Printed Name

Phone Number

Physician's Signature

Assessment Date