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**_____ **POA MPOA DPOA 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Withdrawn/Depressed				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**