Your Hospital's Logo Here

INTERDISCIPLINARY RESIDENT ASSESSMENT

PATIENT IDENTIFICATION

GENERAL INFORMATION

RESIDENT NAME:			PREFERS TO BE CALLED:		
DATE OF ADMISSION:	TIME OF ADMISSION: (Military Time)	ROOM #:	AGE:	RACE:	RETIRED: ☐ Y ☐ N
DATE OF BIRTH:	SEX: ☐ M ☐ F	MARITAL STATUS:	HIGHEST LEVEL OF EDUCATION:	OCCUPATION:	
LANGUAGES SPOKEN :			INFORMATION PROVIDED BY:		
RESPONSIBLE PARTY:			RELATIONSHIP:		

PRIMARY CAREGIVER PRIOR TO ADMISSION:

ADMITTING DIAGNOSIS(ES):

SKILLED NEED(S) (SPECIFY):

PAST MEDICAL HISTORY:

FOOD / DRUG ALLERGIES:

(INDICATED REACTION):

RESIDENT-STATED REASON FOR ADMISSION AS:

RESIDENT-STATED EXPECTATIONS:

WEIGHT:	HEIGHT:	VITALS: BP	T	P	R

RESIDENT EXPRESSES DESIRE TO SELF-ADMINISTER MEDICATION ? ☐ NO ☐ YES IF "YES", COMPLETE SELF-ADMINISTRATION ASSESSMENT FORM

DRUGS (PRIOR TO ADMISSION TO FACILITY)

DRUG (PRESCRIPTION OR OTC)	DOSE	FREQUENCY	INDICATION
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

ALTERNATIVE THERAPIES: ☐ Massage ☐ Acupuncture ☐ Vitamins (list below) ☐ Herbs (list below) ☐ Other (list below)

INFORMATION OBTAINED FROM: ☐ Resident ☐ Family / Responsible Party ☐ Medical Record

KEY (Refer to Appropriate Department for Trigger)

ADMISSIONS | COUNSELING | NUTRITION | SPIRITUAL | PHARMACY | REHAB | SPEECH | FALL | ACTIVITY | SOCIAL SVCS

INOCULATIONS

	RESULT:
LAST PPD DATE:	
LAST TETANUS DATE:	
LAST FLU SHOT DATE:	
LAST PNEUMOVAX DATE:	

PATIENT IDENTIFICATION

ALCOHOL / SMOKING / OTHER

CURRENT TOBACCO USE:	☐ YES ☐ NO	If "YES", list AMOUNT:	DATE OF LAST USE:	YEARS OF USE:
CURRENT ALCOHOL USE:	☐ YES ☐ NO	If "YES", list AMOUNT:	DATE OF LAST USE:	YEARS OF USE:
CURRENT DRUG USE:	☐ YES ☐ NO	If "YES", list AMOUNT:	DATE OF LAST USE:	YEARS OF USE:

✈ NOSE / MOUTH / THROAT (Check all that apply)

ORAL DENTURES ☐ Upper (P / F) ☐ Lower (P / F) FIT OF DENTURES:

MOUTH ☐ Inflamed Gums ☐ Bleeding Gums ☐ Lesions ☐ Mouth Pain ☐ Missing Teeth ☐ Loose Teeth

TEETH ☐ Broken Teeth ☐ Caried Teeth

TONGUE ☐ Discolored Tongue (Describe): ____

THROAT ☐ Sore Throat (Duration): ____

X ♦ ☐ **Difficulty Swallowing** **Explain:** ____

X ♦ ☐ **Difficulty Chewing** **Explain:** ____

X ♦ ☐ **Episodes of Coughing, Clearing Throat or Coughing during Meals** **Explain:** ____

Is this different from swallowing prior to illness? ☐ YES ☐ NO If "YES", explain below:

Have you ever had a swallowing exam? ☐ YES ☐ NO If "YES", explain below:

History of Pneumonia? ☐ YES ☐ NO If "YES", explain below:

✈ RESPIRATORY (Check all that apply)

RESPIRATIONS
- ☐ Even & Unlabored
- ☐ Irregular
- ☐ Shallow
- ☐ Labored
- ☐ Orthopnea
- ☐ Short of Breath - At Rest
- ☐ Short of Breath - With Activity
- ☐ Tachypnea
- ☐ Bradypnea

ANTERIOR: R U L, L U L, R M L, R L L, L L L

POSTERIOR: L U L, R U L, R M L, L L L, R L L

MARK DESCRIPTORS:

D = Decreased
Rh = Rhonchi
A = Absent
R = Rales
W = Wheeze

CHEST APPEARANCE
- ☐ Symmetrical
- ☐ Barrel Chest

COUGH:
- ☐ None
- ☐ Nonproductive (Dry)
- ☐ Productive (Describe Sputum Below)

TREATMENT(S):
- ☐ Nebulizer Type ____ Freq ____
- ☐ Inhaler(s) Type ____ Freq ____
- ☐ O2 Usage: Liter Flow ____

✈ CARDIOVASCULAR & PERIPHERAL VASCULAR (Check all that apply)

HEART Rhythm: ☐ Regular ☐ Irregular Rate: ☐ NSR (60-100 bpm) ☐ Tachy (>100 bpm) ☐ Brady (<60 bpm)

EDEMA: ☐ Dependant ☐ Nonpitting X ♦ **Pitting Edema:** ☐ **1 -** ☐ **2 -** ☐ **3 -** ☐ **4 -**
Location of Edema: ____ Extremities: ☐ Warm ☐ Cool ☐ Dry

PULSES Femoral Palpable: ☐ Right ☐ Left Radial Palpable: ☐ Right ☐ Left
Pedal "dorsalis pedis" Palpable: ☐ Right ☐ Left Pedal "posterior tibial" Palpable: ☐ Right ☐ Left

COMMENTS:

PREVIOUS LEVEL OF FUNCTION

	INDEPENDENT	LIMITED ASSISTANCE	DEPENDENT
Activities of Daily Living			
Transfers			
Bathing			
Dressing			
Toileting			
Ambulation			
Wheelchair Mobility			

PATIENT IDENTIFICATION

MUSCULOSKELETAL (Check all that apply)

HISTORY OF FALLS: ☐ Yes ☐ No If YES, Explain: ____________________

FALL ASSESSMENT

RISK FACTOR	POINTS	√ IF PRESENT	SCORE
Age ≥ 65	**1**	☐ PRESENT	______
Confused / Disoriented / Hallucinating or Resistive Behaviors	**2**	☐ PRESENT	______
History of Falls (Last 12 Months)	**2**	☐ PRESENT	______
Experiencing Pain	**1**	☐ PRESENT	______
Recent History of Loss of Consciousness or Seizure Disorder	**1**	☐ PRESENT	______
Receiving Psychoactive Medication	**2**	☐ PRESENT	______
Receiving Diuretic Medication	**1**	☐ PRESENT	______
Receiving Cardiovascular Medication / Postural Hypotension	**1**	☐ PRESENT	______
Abnormal Elimination Needs	**2**	☐ PRESENT	______
Impaired Mobility / Balance / Gait	**2**	☐ PRESENT	______
Poor Eyesight	**1**	☐ PRESENT	______
Poor Hearing	**1**	☐ PRESENT	______
Drug / Alcohol Problem	**1**	☐ PRESENT	______
Post Operative Sedated / Condition	**1**	☐ PRESENT	______
Language Barrier	**1**	☐ PRESENT	______
RISK OF FALL when Resident Score ≥ 4		**RESIDENT SCORE**	______

Residents who score > 4 will be reviewed by the FALL COMMITTEE within 1 week.

PATIENT IDENTIFICATION

✈ MUSCULOSKELETAL [Continued] (Check all that apply)

POOR SAFETY AWARENESS: ☐ Yes ☐ No Explain: ____

ASSISTIVE DEVICES: ☐ Cane ☐ Walker ☐ Crutches ☐ Prosthesis / Brace __RA __LA __RL __LL

EQUIPMENT BROUGHT FROM HOME: ____

USE OF SIDERAILS / TRAPEZE FOR BED MOBILITY PRIOR TO ADMISSION: ☐ Yes ☐ No If YES, Explain: ____

AMPUTATION: ____

FRACTURE(S): ☐ Yes ☐ No If YES, Describe Location: ____

JOINTS: ☐ Joint Swelling (Location): ____ ☐ Joint Pain (Location): ____
☐ Hot to Touch (Location): ____ ☐ Contractures (Location): ____
Comments: ____

MOTOR STRENGTH & SENSATION:
☐ Weakness: __RA __LA __RL __LL Describe: ____
☐ Paralysis: __RA __LA __RL __LL Describe: ____
☐ Tingling: __RA __LA __RL __LL Describe: ____
☐ Numbness: __RA __LA __RL __LL Describe: ____

✈ GASTROINTESTINAL (Check all that apply)

ABDOMEN: ☐ Soft ☐ Nontender ☐ Tender ☐ Distended ☐ Obese ☐ Gastric Upset ☐ Heartburn
☐ **G-Tube** ☐ **J-Tube** ☐ Experiences Chest Pain
☐ **Recent Nausea / Vomiting** ☐ **Feeling of Food Stuck in Throat**

BOWEL Sounds: ☐ Normal ☐ Absent ☐ Hypoactive Elimination Pattern: ____

BOWEL: ☐ Constipation ☐ Diarrhea ☐ Incontinence BM Frequency: ____
☐ Bloody Stools ☐ Tarry Stools ☐ Colostomy (when): ____ ☐ Ileostomy (when): ____

✈ GENITOURINARY / GYNECOLOGY (Check all that apply)

URINATION: ☐ WNL ☐ Dysuria ☐ Oliguria ☐ Hematuria ☐ Urgency ☐ Hesitancy

FREQUENCY: ____ Times per DAY ____ Times per NIGHT ☐ Anuria / Dialysis ☐ Incontinence
☐ Catheter ☐ UTI ☐ Urostomy ☐ Needs Toileting ☐ Potential for Retraining

HISTORY OF STDs: ☐ Yes ☐ No If YES, Describe: ____

MALE REPRODUCTIVE: ☐ Urethral Discharge ☐ Scrotal Edema Comments: ____

FEMALE REPRODUCTIVE: ____ Most Recent PAP ☐ Vaginal Discharge ☐ Vaginitis
Comments: ____

NUTRITION

WEIGHT LOSS: ☐ Yes ☐ No If YES, Intentional: ☐ Yes ☐ No **Wt Loss > 10lbs:** ☐ **Yes** ☐ **No**

FOOD INTOLERANCES (Describe): ____

FEEDING ABILITY ☐ Self ☐ Needs Cuing ☐ Dependent ☐ Self-Help Feeding Device

THERAPEUTIC HOME DIET: ☐ Yes ☐ No If YES, Explain: ☐ Regular ☐ Soft ☐ Thickened Liquids ☐ Pureed ☐ Other ____

INTAKE: ☐ PO Only ☐ Alternative Method Only ☐ PO and Alternative Method

ADDITIONAL NUTRITIONAL SUPPLEMENTS (Specify): ____

HISTORY OF DEHYDRATION: ☐ Yes ☐ No If YES, provide most Recent Date: ____
Most Recent BUN Value: ____ Date of BUN: ____

COMMENTS: ____

SLEEP CYCLE ASSESSMENT

☐ AWAKE SEVERAL TIMES DURING THE NIGHT (Describe):

☐ CHANGE IN USUAL SLEEP PATTERN (Describe):

☐ Insomnia ☐ Unpleasant Mood in AM ☐ Takes Meds for Sleep

Describe Sleep Meds ______

HAS A BEDTIME RITUAL (Describe):

PATIENT IDENTIFICATION

COMMUNICATION

SPEECH CLARITY: ☐ Clear ♦ ☐ **Unclear** ☐ **No Speech**

MODE OF COMMUNICATION ☐ Writing ☐ Sign ☐ Sounds / Gestures ☐ Communication Board ☐ Nonverbal

ABILITY TO UNDERSTAND OTHERS: ☐ Understands ☐ Usually ♦ ☐ **Sometimes** ☐ **Rarely**

MAKING SELF UNDERSTOOD: ☐ Understood ☐ Usually ♦ ☐ **Sometimes** ☐ **Rarely** INTERPRETER: ☐ Needed ☐ Not Needed

RESPONSE TO VERBAL STIMULUS: ☐ Looks in Direction of Speaker ☐ Makes Appropriate Verbal Response ☐ Makes Appropriate Non Verbal Response ☐ Opens Eyes ☐ None of the Above

COMMENTS: ______

HEARING

HEARING: ☐ Adequate ☐ Adequate with Assisted Living Device ☐ Minimal Difficulty ☐ Highly Impaired

HEARING AID: ☐ No Hearing Aid ☐ Hearing Aid Present, But Not Used ☐ Hearing Aid Present & Used: ____ L ____ R

COMMENTS: ______ Last Hearing Exam Date: ______

VISION

VISION: ☐ Adequate ☐ Adequate with Glasses ☐ Impaired - Mild ☐ Impaired - Moderate ☐ Impaired - Severe

VISION AID: ☐ Glasses ☐ Contact Lenses ☐ Magnifying Glass ☐ Other ______

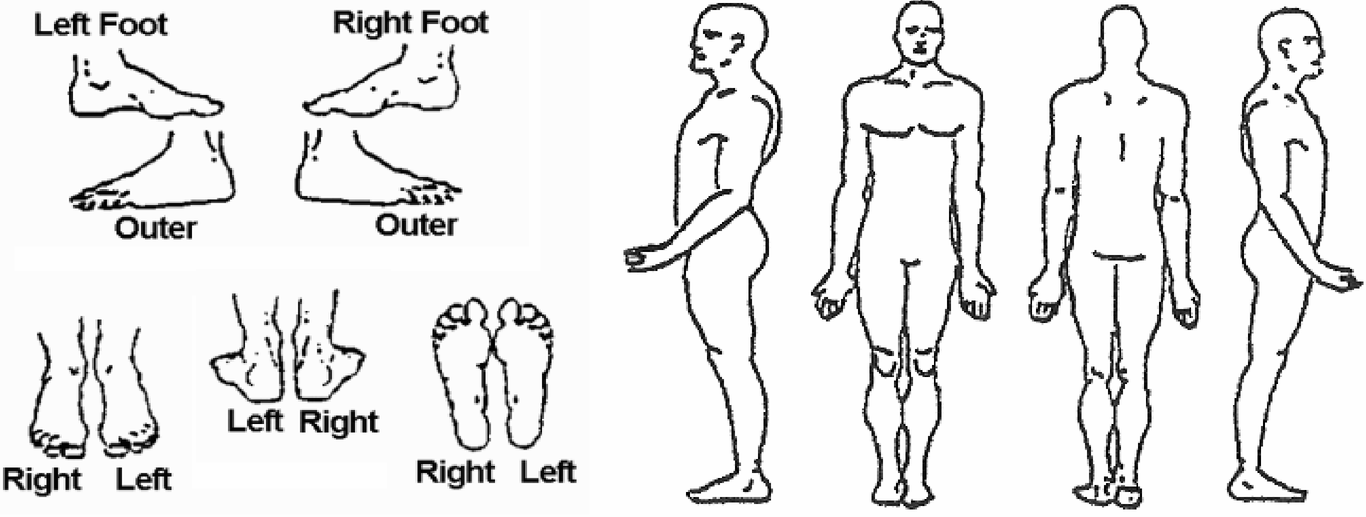
COMMENTS: ______ Last Vision Exam Date: ______

✈ SKIN

SKIN: ☐ Clear ☐ Intact ☐ Cool ☐ Dry ☐ Warm ☐ Diaphoretic ☐ Jaundiced
☐ Flushed ☐ Pale ☐ Cyanotic ☐ Petechiae ☐ Flaky ☐ Poor Turgor ☐ Ecchymosis
☐ Itching ☐ Rash ☐ Lesion ☐ Burn ☐ Blister ☐ Skin Tear ☐ Stasis Ulcer(s)

X ♦ ☐ **Reddened Area(s)** ☐ **Pressure Ulcer(s)** ♦ ☐ **Incision**

COMMENTS: ______



COMMENTS: ______

PATIENT IDENTIFICATION

SKIN IMPAIRMENT

STAGE KEY: **I** = Reddened Area Contact Skin; **II** = Blister, Skin Break
III = Skin Break Exposing Subcutaneous Tissue; **IV** = Skin Break Exposing Muscle / Bone

LOCATION	SIZE (LxWxD)	APPEARANCE	STAGE

BRADEN PRESSURE ULCER RISK ASSESSMENT

Indicate appropriate score on right column of table. NOTE: Bed and chairbound individuals with impaired ability to reposition themselves should be assessed for risk of developing pressure ulcers. Periodically reassess residents with established pressure ulcers.

CATEGORY	STAGE 1	STAGE 2	STAGE 3	STAGE 3	SCORE
SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related discomfort.	**1. Completely Limited** Unresponsive (does not moan, flinch or grasp to painful stimuli, due to a diminshed level of conscienceness or sedation **-OR-** limited ability to feel pain over most of body surface.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **-OR-** has a sensory impairment limiting ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or need to be turned **-OR-** has some sensory impairment limiting ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit limiting ability to feel pain or discomfort.	
MOISTURE: Degree of skin exposure to moisture.	**1. Constantly Moist** Skin is always moist from perspiration, urine, etc. Dampness is detected every time resident is moved / turned.	**2. Very Moist** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.	
ACTIVITY: Degree of physical activity.	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Can not bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during the day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside of room at least twice a day and inside room at least once every 2 hours during waking hours.	
MOBILITY: Ability to reposition & & control body.	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations** Makes major and frequent changes in position without assistance.	
NUTRITION: Usual food intake pattern.	**1. Very Poor** Never eats complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal, and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feed.	**3. Adequate** Eats over half of most meals Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement if offered. Or is on a tube feeding or TPN regimen which probably meets most of Resident's nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	
FRICTION / SHEAR: Ability to control & change	**1. Problem** Requires moderate to maximum assistance moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		
				TOTAL SCORE	

© 1988 Barbara Braden and Nancy Bergstrom. Reprinted with Permission. 1. Braden BI. Bergstrom N. Clinical utility of the Braden Scale for Predicting Pressure Sore Risk. *Decubitus* , 1989; 2:44-51.

✈ PAIN ASSESSMENT / EVALUATION

SOURCE OF INFORMATION: ☐ Resident ☐ Medical Record / MD ☐ Nurse ☐ Family / Friend (name): ____

1. Are you in Pain now? ☐ Yes ☐ No
2. Have you had Pain in the last 7 days? ☐ Yes ☐ No ☐ Unknown

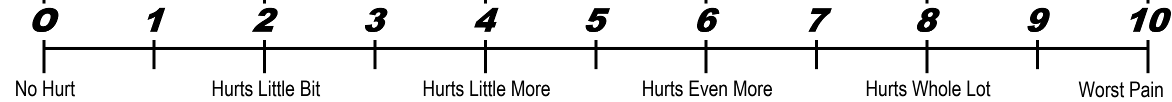
If "Yes" to either Question #1 or #2, answer Questions #3 - 10 below:

PATIENT IDENTIFICATION

3. a) What is causing the pain? ____
   b) Where is the pain located? ____
   c) How often is the pain present? ☐ Constant ☐ Intermittent ☐ Infrequent (< 1x per day)
   d) What type of pain? ☐ Dull ☐ Sharp ☐ Burning ☐ Radiating ☐ Numbing ☐ Other ____
   e) What is pain intensity (using rating scale below)? ____

WONG-BAKER:
(Faces)

0-10 VISUAL:
(Numeric)



VERBAL: No Hurt — Hurts Little Bit — Hurts Little More — Hurts Even More — Hurts Whole Lot — Worst Pain

NON-COGNITIVE:
(FLACC Scale)

WONG-BAKER FACES PAIN SCALE from Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Ahmann E, DiVito-Thomas PA, Whaley & Wong: Nursing Care of Infants & Children, 6th ed, St. Louis, MO: Mosby-Year Book Inc., 1999; 1153. Copyrighted by Mosby-Year Book, Inc. Reprinted with Permission.

	____ FACE	____ LEGS	____ ACTIVITY	____ CRY	____ CONSOLABILITY
1. Sum Face, Legs, Activity, Cry & Consolability Scores to calculate FLACC Score **2.** Record FLACC Score using 0-10 NUMERIC Scale above	0 = No particular expression or smile 1 = Sporadic grimace / frown, withdrawn, disinterested 2 = Frequent / constant frown, clenched jaw, quivering chin	0 = Normal position, or relaxed 1 = Uneasy, restless, tense 2 = Kicking, or legs drawn up	0 = Lying quietly, normal position, moves easily 1 = Squirming, shifting back & forth, tense 2 = Arched, rigid, or jerking	0 = No cry (awake or asleep) 1 = Moans or whimpers, occasional complaint 2 = Crying steadily, screams, sobs, frequent complaints	0 = Content, relaxed 1 = Reassured by occasional touching, hugging, or 'talking to', distractable 2 = Difficult to console or comfort

4. What makes the pain worse? ____
5. What makes the pain better? ____
6. List nonverbal cues / behavior indicating pain below (i.e., grimacing, moaning, flinching, striking out, rubbing, etc.)
   ____
7. Any exacerbating factors present? ☐ None ☐ Decubitus ☐ Post-fall ☐ Infection ☐ Anxiety ☐ Malignancy process (i.e., cancer) ☐ Disease process (i.e., cancer) ☐ Other ____
8. List Pain Medications in use: ____ Describe Medications' Effectiveness ____
9. List any other Pain alleviating processes: ☐ Positioning ☐ Massage Therapy ☐ Warm Application ☐ Cool Application ☐ Diversion (specify technique) ____ ☐ Other ____
10. What effect on ADLs and Quality of Life (explain): ____

COMMENTS: ____

LEARNING ABILITY & READINESS

RESIDENT: ☐ Yes ☐ No FAMILY / CAREGIVER: ☐ Yes ☐ No

BARRIERS TO LEARNING: ☐ Language Barrier ☐ Cultural / Religious Difference ☐ Emotional Status ☐ Physical ☐ Ability to Comprehend ☐ Hearing / Visual Impairments ☐ None ☐ Other ____

LEARNING STYLE: ☐ Verbal ☐ Written ☐ Visual ☐ Demonstration ☐ Other ____

PSYCHOSOCIAL (Check all that apply)

RESIDENT SHOWS EVIDENCE OF: ☐ Anxiety ☐ Anger ☐ Depression ☐ Fear ☐ Recent Loss ☐ Withdrawl ☐ Agitation ☐ Denial ☐ Suicide Risk ☐ Hallucinations ☐ Paranoia ☐ Delusional ☐ Confusion ☐ Impulsivity ☐ Family Dysfunction Conflict ☐ Anti-Social Behavior

INAPPROPRIATE BEHAVIOR: ☐ Inappropriate Behavior ☐ Wandering ☐ Verbally / Physically Abusive ☐ Resists Care

PSYCHOLOGICAL EVALUATION IN LAST 90 DAYS? ☐ Yes ☐ No If "Yes", diagnosis: ____

SPECIAL NEEDS / CONCERNS: ____

RESIDENT / RESIDENT'S FAMILY APPEAR TO BE IN AN IMMEDIATE STATE OF CRISIS: ☐ Yes ☐ No

COMMENTS: ____

GENERAL ACTIVITY

Check all that apply: **P** = Past **C** = Current **N** = No Interest

	P	C	N		P	C	N
Cards / Other Games				Trips / Shopping			
Arts & Crafts				Walking / Wheeling			
Exercise / Sports				Watching TV			
Music				Gardening / Horticulture			
Reading / Writing				Talking / Conversing			
Spiritual / Religious				Pets			

Preferred Activity Setting

PATIENT IDENTIFICATION

COGNITION / MENTAL STATUS (Check all that apply)

HISTORY OF MENTAL ILLNESS: ☐ Yes ☐ No If YES, Explain: ____________

☐ **Short Term Memory Loss** ☐ **Long Term Memory Loss** Onset of Memory Loss: ____________

☐ **Confused** **Orientation** ☐ **Person** ☐ **Time** ☐ **Place** ☐ **Situation**

☐ **Comatose** ☐ **Nonresponsive**

Able to Follow Instructions ☐ **One-Step** ☐ **Two-Steps** ☐ **Multiple Steps**

DISCHARGE POTENTIAL (Check all that apply)

1. Resident expresses / indicates preference to return to the community: ☐ Yes ☐ No
2. Resident has a support person who supports discharge: ☐ Yes ☐ No Support Person's Name: ____________
3. Projected length of stay: ☐ LTC ☐ Short-Term ☐ Complex Discharge
4. Previous living arrangement: ____________ How Long? ____________
5. Outside intervention / services: ____________
6. Other support persons / resources: ____________

SPIRITUAL (Check all that apply)

Religious / spiritual affiliation of Resident: ____________

Interested in participating in religious activities: ☐ Yes ☐ No

Describe religious / spiritual requests: ____________

Does resident want church / clergy contacted? ☐ Yes ☐ No

Cultural / ethnic needs: ____________

ABUSE / NEGLECT SCREENING (Check all that apply)

Has anyone at Resident's home tried to hit, injure or threaten Resident? ☐ Yes ☐ No If "Yes", explain below

Do any of the following exist in Resident's previous living environment? INTERVIEWER: Specify "O" for Observed; "A" for Answered

____ Drug / Alcohol Abuse ____ Impaired Caregiver ____ Isolation from Others ____ Sexual Abuse

____ Physical Abuse ____ Psychological Abuse ____ Financial Abuse

ADVANCED DIRECTIVES (Check all that apply)

Living Will ☐ Yes ☐ No Durable Power of Attorney for Healthcare Decisions: ☐ Yes ☐ No

Durable Power of Attorney for Financial Decisions: ☐ Yes ☐ No Copy of Documents on Chart: ☐ Yes ☐ No

DECISION MAKER: ____________ GUARDIAN: ____________

CODE STATUS: ☐ Full Code ☐ No CPR - Medical Heroics ☐ Do NOT Hospitalize

COMMENTS: ____________

ASSESSMENT / INFORMATION PROVIDERS

ASSESSMENT COMPLETED BY:	RN NAME:	TITLE:	DATE:	TIME: (Military Time)
ADDITIONAL INFORMATION PROVIDED BY:	NAME:	TITLE:	DATE:	TIME: (Military Time)
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