H U ASSISTED LIVING RESIDENT ASSESSMENT

*****Initial Assessment should be done in presence of potential resident*****

Section One - General Information

Resident Name:	DOB:	Male___ Female___	**Code Status** **FULL_______ DNR _______** **CMO_______ MOLST_____**
Medicaid #		Medicare #	
Current Address:			
City:	State:	Zip:	
Referred by:		Phone:	
Individual:	Agency:		
Telephone:	Date:		
Primary Physician:		Phone:	
Other Physicians:		Phone:	
		Phone:	
		Phone:	
Hospice Services:	Yes:	No:	
Date Hospice Services Began:			
Allergies :			

Emergency/Family Contacts	Relationship:	Telephone:

Reason(s) resident is requesting admission to ALR:	
	Alternate Decision Maker**:**
	None
	Guardian
	Power of Attorney (Health Care)
	Power of Attorney
	Living Will
	Rep Payee
	Name:
	Phone:
	Relationship:

Assessment Date(s)/Types:			
Initial:	Date:	Reviewed	Signed
Update:	Date:	Reviewed	Signed
Update:	Date:	Reviewed	Signed

Section Two – Activities of Daily Living

Directions: (Note: Identify each update by writing date in margin next to change)
Check One of the Following Codes:
N=None MI-Minimal MO=Moderate E=Extensive T=Total

Activity	Assistance Required	Comments:
Eating Meals: Identify the level of assistance needed to perform the activity of feeding and eating (list special equipment if regularly used)	___**N** ___**MI** ___**MO** ___**E** ___**T**	
Toileting: Identify the level of assistance needed to get to and from the toilet	___**N** ___**MI** ___**MO** ___**E** ___**T**	
Ambulation: Identify the level of assistance needed to get around, both inside and outdoors (list mechanical aids if needed)	___**N** ___**MI** ___**MO** ___**E** ___**T**	
Transferring: Identify the level of assistance needed to transfer independently.	___**N** ___**MI** ___**MO** ___**E** ___**T**	
Personal Hygiene: Identify the level of assistance needed to maintain personal hygiene (shave, care for mouth, comb hair, etc.)	___**N** ___**MI** ___**MO** ___**E** ___**T**	
Dressing: Identify the level of assistance needed to dress and undress, including the selection of clean clothing, appropriate seasonal clothing.	___ **N** ___ **MI** ___ **MO** ___ **E** ___ **T**	
Bathing: Identify the level of	___**N** ___**MI**	

assistance needed to bathe and wash hair.	___MO ___E ___T	

SECTION THREE – FUNCTIONAL ABILITIES

Directions: (Note each update by writing date in margin next to change) Check one of the following codes:
N=None MI=Minimal MO=Moderate E=Extensive T=Total

Activity	**Assistance Required**	**Comments:**
Finances: Identify the level of assistance the resident requires to manage his/her own finances.	___N ___MI ___MO ___E ___T	
Shopping: Identify the level of assistance the resident requires to shop for personal needs, etc.	___N ___MI ___MO ___E ___T	
Laundry: Identify the level of assistance needed to do own laundry.	___N ___MI ___MO ___E ___T	
Housekeeping: Identify the level of assistance needed to attend to housekeeping tasks, clean surfaces, living quarters.	___ N ___ MI ___ MO ___ E ___ T	
Night Needs: Identify the level of assistance needed at night and/or nightly checks.	___N ___MI ___MO ___E ___T	
Health Services: Identify the level of assistance needed to arrange for own health and supportive services.	___ N ___ MI ___ MO ___ E ___T	
Recreational/Social Activities: Identify the level of assistance needed to arrange own recreational or social activities.	___N ___MI ___MO ___E ___T	**Previous Occupation:** **Activities of Choice:**
Religious and/or Spiritual Needs: Identify the resident's desire and/or ability to participate in religious or spiritual activities.	**Religion:** ____________ _	**Participation:** ___Participates ___None by Choice ___Not able
List any medical equipment the resident requires (ex. cane,	**1.**________________________________ **2.**___________________________________	

walker, wheelchair, oxygen tank)	**3.**_________________________________ **4.**_________________________________
Level of assistance needed to regulate and administer oxygen.	

Section Four – Behavioral Information	
Check One Answer for Each Question Below:	
Wandering: moving about aimlessly; wandering without purpose or regard to safety. ___does not wander. ___wanders within residence or facility. May wander outside; health or safety may be jeopardized, but resident is not combative about returning and does not require professional consultation and/or intervention. ___wanders outside and leaves immediate area. Has consistent history of leaving immediate area, getting lost, or being combative about returning. Requires constant supervision, behavioral management, intervention, and/or professional consultation.	**Comments:**
Assaultive/destructive behavior: Assaultive or combative to others (throws objects, strikes or punches, bites, scratched, kicks, makes dangerous maneuvers, destroys property etc.). ___is not Assaultive or dangerous. ___is sometimes Assaultive. Requires special tolerance or management, but does not require professional consultation and/or intervention. ___is frequently Assaultive, and may require behavioral management, intervention and/or professional consultation. ___is Assaultive, and requires constant supervision, behavioral management, intervention and/or professional consultation.	**Comments:**
Danger to self: indicated by self-neglect, suicidal thoughts, self mutilation, suicide attempts, etc. ___does not display self-injurious behavior. ___displays self-injurious behavior but can be redirected away from those behaviors. ___displays self-injurious behavior, and behavior control intervention and/or medication may be required to manage behavior. ___displays self-injurious behavior and required constant supervision with intervention and/or medication.	**Suicide attempts on the following dates:** ______________________________ ______________________________ **Method used in attempts:** ______________________________
Self-preservation: ability to avoid situations in which he/she may be in danger. ___is clearly aware of surroundings, able to discern and avoid situations in which he/she may be in danger, and physically capable of self-preservation and/or evacuation in emergencies. ___is able to discern situations in which he/she may be in danger but due to physical limitations may need some assistance to self-preserve or evacuate. ___is frequently confused and unable to discern and/or avoid	

situations in which he/she may be in danger and needs guidance and assistance. ___requires constant supervision due to his/her inability to self-preserve. **Note: Persons residing in F2 level licensure must be capable of self-preservation including evacuating the building w/o assistance in emergency situations.**	

Section Five – Health Information

Current Medical Diagnoses:

Psychosocial History:

Current Mental Health Diagnoses:
(Depression, Anxiety Disorders, Bi Polar, Schizophrenia, Other)
History of Abuse ___Yes ___No
History of: Substance Abuse: ___Yes ___No
If yes, ________Drugs _________Alcohol
Attends Day Program: ___Yes ___No
Name: ____
Location: ____
Case workers Name: ______________________________________ Phone: _______________________
Probation: ___ Yes ___No
Probation Officer's Name: ____
Phone: ______________________
Is the resident currently under the care of a psychiatrist? ___Yes ___No
MD's Name____ Phone:____________________
Dementia ___Yes ___No Cognitive Assessment Score: _________

Other Problems:
Cardiological____

Respiratory____

Gastrointestinal____

Neurological____

Muscular/skeletal____

Skin Issues: ___Yes ___No
If yes, you must complete the attached Skin Assessment"

<table>
<tr><td colspan="2">Infectious Disease _______________ Bloodborne_________________ Other_________________</td></tr>
<tr><td>History of Falls
___ None
___ Some Date Last Fall __________
___ Frequent

___ Monitoring required
___ Fall risk evaluation required
(note: frequent falls requires “Fall Risk Evaluation” to be completed.</td><td>Sleep Habits and Problems:

Apnea Machine ___Yes ___No</td></tr>
<tr><td>Bladder Control: (check one)
___ Continent
___ Occasional Incontinence
___ Frequent Incontinence
___ Total Incontinence
___ Catheter
Type & Size____________________
___ Assistance needed to manage catheter
___ Briefs Assistance ___Yes ___No</td><td>Bowel Control: (check one)
___ Continent
___ Occasional Incontinence
___ Frequent Incontinence
___ Total Incontinence
___ Ostomy – level of assistance needed to manage appliance _________________
___Briefs Assistance ___Yes ___No</td></tr>
<tr><td colspan="2">Treatments/Therapies ___ Check here if none

List any current treatment/therapies resident is currently under and their frequency (ex. Physical therapy, respiratory therapy):

Will assistance with follow through be necessary? ___ Yes ___No
Comments:</td></tr>
<tr><td colspan="2">Communication:
Aphasia: ___Expressive ___Receptive
Communication Device ___Yes ___No Type ____________________________________
Level of Assistance needed to manage device:</td></tr>
</table>

Sign language use: ___Yes ___No
Primary language: ______________________
Able to ___Understand ___Speak ___Read ___Write
Secondary language: ____________________
Able to ___Understand ___Speak ___Read ___Write

Vision	Hearing
Glasses ___Yes ___ No ___ Adequate ___ Impaired – sees large print but not regular print ___ Moderately impaired – limited, cannot see headlines ___ Severely impaired – no vision or sees only light	Hearing Aid ___Yes ___No ___ Hears adequately ___ Minimal difficulty ___ Intermittently impaired ___ Highly impaired

Dental

___Yes ___No Natural Teeth
___Yes ___No Edentulous
___Yes ___No Dentures
___Yes ___No Partial
___Yes ___No Other Dental Appliances (mouth guards)
___Yes ___No Loose fitting dentures/partials
___Yes ___No Chips/cracks teeth/dentures
___Yes ___No Inflamed or bleeding gums
___Yes ___No Chewing problems
___Yes ___No Mouth Pain/discomfort

Last Dental Visit/Exam ____
Brush/Floss How often ____
___Yes ___No Need assistance with oral hygiene

Diet Information
Currently on special diet ordered by physician? ___Yes ___No
Is resident following the prescribed diet? ___Yes ___No
Has the resident had an unplanned weight loss or weight gain of 10 or more pounds in the last 6 months? ___Yes ___No Current Weight______(pounds)
Please specify type of diet:
___ADA calorie-calculated
___Diabetic
___Regular diet w/added nutrients

___Low cholesterol
___Lactose intolerance
___Regular diet w/o concentrated sugar
___Low Fat
___Liquid
___Regular diet w/o added salt
___Restricted sodium
___Other ____

Resident's height (initial assessment)_______________
Resident's weight (initial assessment)_______________
Appetite:

Potential Diet Problems?

Yes No
___ ___ Does resident have mouth or tooth problems that make it hard to chew?
___ ___ Has resident gained or lost ten or more pounds in the last 6 months w/o wanting to?
___ ___ Is resident able to self feed?
___ ___Does resident have difficulty swallowing?
___ ___ Nausea/Vomiting?
___ ___ Heartburn/Reflux?
___ ___ Aspiration Precautions?

Section Six - Medications	
___Resident will self administer medication ___Needs medication administration	
___Total Number of Medications Prescribed	
Name/Dosage (List)	Frequency
Is resident an Insulin dependent Diabetic? ___Yes ___No	If yes, what level of assistance is needed to administer Insulin?
Glucose monitoring? ___Yes ___No	If yes, what level of assistance is needed to monitor glucose?

Comments regarding medication use:

Does resident use any over the counter medications (OTC) or home remedies?
Yes___ No___ (if yes, please list)

Has Resident received Influenza Vaccine? ___Yes ___No Date:____________________
Has Resident received Pneumovax : ___Yes ___No Date:____________________
Tuberculin Status: ___ Negative ___ Positive ____ Unknown____

Self Medication Assessment

(to be completed on all residents self administering medications)

Resident has cognitive ability to self administer: ___Yes ___No
___with assistance ___with supervision

Physical limitations:

List any assistance needed (ex. oversight, reminding):

Comments:

Section Seven – Assessment Summary

Conclusion Level of service required/recommended ___F1 ___F2 ___M1 ___M2 ___Special Care Unit Resident is suitable for ALR admission or continued residence: _____Short term _____Long Term _____With Accommodations _____Not Suitable	Limited Health Care: List Services: 1.______________________________ 2.______________________________ 3.______________________________ 4.______________________________ 5.______________________________

Physical Limitations:

Health Needs:

Other Recommendations:

Assessment Completed By:

Date of Assessment: ______________

____ ________________________________

Please Print

Time & Location of Assessment

____ ________________________________

RN Signature

Person Providing Information

____ ________________________________

Administrator Approval

Date

____ ________________________________

Resident Signature

Date

If admitted to ALR, date of admission: ____