Oklahoma State Department of Health
Long Term Care Service
123 Robert S. Kerr Ave., Suite 1702
Oklahoma City, OK 73102-6404
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Recommended Assisted Living Resident Assessment Form

All Areas Must Be Addressed, "N/A" if not applicable. ** Denotes items required for Admission Assessment.*

Admission Date_____

Facility Name_____ **Assessment Date**_____

Resident Name_____ **Room #**:____ **Date of Birth**:_____

Assessment Type *(circle* one): Preadmission 14 day Annual Significant Change

***Disease Diagnoses and Medically Defined Conditions:**

_____

_____

***History of Infections and Prior Medical History:**

_____

***List All Current Medications and dosages (list additional medications on separate page if needed):**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Mental / Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) *(circle one)

Alert / Non-Alert / Oriented x ____ Confused / Confused at Times / Forgetful Judgment: *G / F / P*

_____

***Mental Health History / Mental Retardation or Developmental Disabilities:**

_____

***Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):**

Mobility: G / F / P Strength: G / F / P Gait: *G / F / P*

Range of Motion: Full / Limited / Contractures (describe)_____

Weight Bearing: Yes / No (describe)_____

Ambulatory Without Assistance / With Staff Assistance (describe)

_____

Bedfast / Chair fast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

*List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:

Bathing_____ Eating_____ Dressing_____ Transferring_____ Toileting_____ Ambulation_____

Devices/Restraints (Describe):

Side rails used? Yes / No

Restraint Devices (Describe)_____ Utilized When and Why (describe)_____

Assisted Living Resident Assessment Form

Oral / Nutritional Status:

Diet Order:_____ Height:_____ Weight:_____ Weight Changes (loss or gain)_____

Abnormalities: Swallowing Problem Yes / No Nausea / Vomiting (describe)_____

Ability to Eat: Independent / Meal Set Up & Cueing / Assistance to Use Utensils/ Supervision / Must be Fed

Oral Status: Own Teeth / Partial Teeth / Dentures / No Teeth / Condition of Teeth (describe)_____

Tube Feeding: Gastrostomy / Nasogastric (describe) _____

***Toileting Ability / Elimination:**

Bladder: Continent / Incontinent / Incontinent at times (describe) / Urinary Catheter – Indwelling / Other

Bowel: Continent / Incontinent / Incontinent at times (describe)_____

Toileting Ability: Independent / Assist / Total Assist / Adult Briefs / B&B Restoration / Toileting Schedule

Customary Routine (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Sleep habits: G / F / P How Many Hours in 24?_____ Sleep Problems (describe)_____

Meals: In Dining Room / In Room / Other Location / Eats Out (describe frequency)_____

Bathing: Prefers bath / Prefers shower / Preferred schedule (describe)_____

Usual time to rise_____ Usual bedtime_____ Naps during day?_____

Psychosocial Status: (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Ability to communicate: G / F / P Interviewable: Yes / No. If No describe:_____

Usual Mood: Calm / Fearful / Agitated / Anxious_____

History of Mood Disorder / Depression:_____

History of Abnormal Behaviors: Agitation / Anger Outburst /Crying / Aggressive / Combative / Elopement Risk

Family / Friends Involvement: Yes / No (describe)_____

Skin Condition (G=Good, F=Fair, P=Poor, if fair or poor, describe):

General Condition: G / F / P_____ Turgor: G / F / P_____

Describe Color, Texture and Appearance: _____

Describe Abnormalities: _____

Wounds (Describe All: location, size, color, drainage, treatment):_____

_____

Special Treatments and Procedures (i.e. wound care, respiratory therapy, physical therapy, restorative, etc.):

_____

Sensory and Physical Impairments (i.e. vision, hearing, etc.):

_____

_____ _____ _____

Signature of Resident or Representative Interviewed *Participating Health Professional* *Date*

_____ _____ _____ _____

**Signature (R.N. or Physician), Title* *Date* *Participating Health Professional* *Date*