**Recommended Assisted Living Resident Assessment Form**

**Oklahoma State Department of Health**
**Long Term Care Service**
**123 Robert S. Kerr Ave., Suite 1702**
**Oklahoma City, OK 73102-6404**
**Phone: (405) 426-8200**

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**All Areas Must Be Addressed, "N/A" if not applicable.**

* Denotes items required for Admission Assessment.

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**Admission Date**

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**Resident Name**

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**Room #:**

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**Date of Birth:**

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**Assessment Type** (circle one):

- Preadmission
- 14 day
- Annual
- Significant Change

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

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

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

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**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

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

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**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

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

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Weight Bearing: Yes / No (describe)

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Ambulatory Without Assistance / With Staff Assistance (describe)

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

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

- Bathing
- Eating
- Dressing
- Transferring
- Toileting
- Ambulation

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**Devices/Restraints (Describe):**

- Side rails used? Yes / No

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

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### 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: ________