Protective
Health Services

Oklahoma State
Department of Health

Long Term Care
1000 Northeast Tenth Street
Oklahoma City, OK 73117
Phone (405) 271-6868

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):**

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

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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

____

***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 Problems 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*