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 <u>must be capable of self-preservation including evacuating the building w/o assistance in emergency situations.</u>**	

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"

Infectious Disease _____ Bloodborne_____ Other_____

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.***	Sleep Habits and Problems: Apnea Machine ___Yes ___No
Bladder Control: (check one) ☐ Continent ☐ Occasional Incontinence ☐ Frequent Incontinence ☐ Total Incontinence ☐ Catheter Type & Size_____ ☐ Assistance needed to manage catheter ☐ Briefs Assistance ___Yes ___No	Bowel Control: (check one) ___ Continent ___ Occasional Incontinence ___ Frequent Incontinence ___ Total Incontinence ___ Ostomy – level of assistance needed to manage appliance _____ ___Briefs Assistance ___Yes ___No

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:

Communication:
Aphasia: ___Expressive ___Receptive
Communication Device ___Yes ___No Type _____
Level of Assistance needed to manage device:

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: _____