Galaxy Hosted Software Blank Assessment Examples

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Nick M. D'Angelo, Sr
3/1/2013

ACCIDENT OR INCIDENT REPORT

(Report all accidents or incidents even if no apparent injury)

NAME Last First Middle	Attending Physician	Record No	Room / Bed

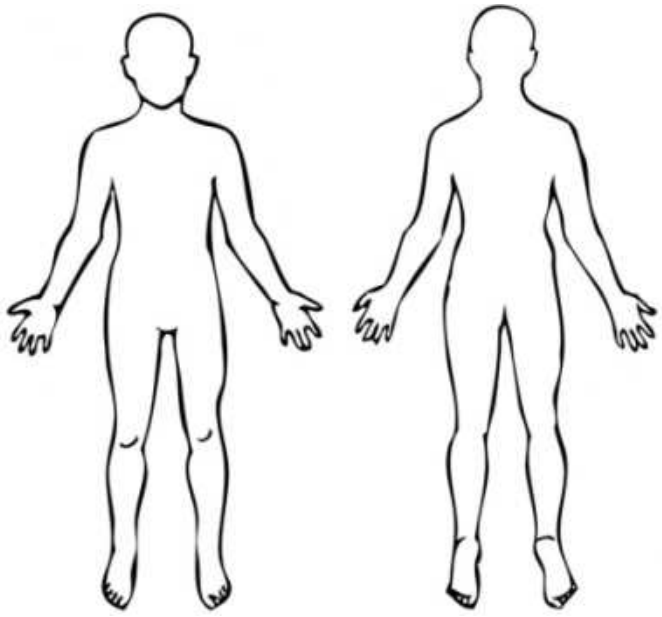
Date of accident or incident ___-___-_____ Time : : Place

Was it necessary to notify physician? ☐ Yes ☐ No Time of notification : :

Name of physician Name of supervising nurse

Describe nature of accident or incident and injuries received:

Illustrate on the diagram position or place of injury, if any: T.R.P B.P.



Date report written ___-___-_____ Time : : Signed

PHYSICIAN OR NURSE

Activities Assessment

Activities Assessment For: Room / Bed:

(Name of Resident)

Admission Date: __-__-____ Attending Physician: Assessment Date:

Elements of Assessment	Assessments							
	1st	2nd	3rd	4th	5th	6th	7th	8th
	__-__-____	__-__-____	__-__-____	__-__-____	__-__-____	__-__-____	__-__-____	__-__-____
Orientation								
Knows whereabouts at all times	☐	☐	☐	☐	☐	☐	☐	☐
Knows day, month, year at all times	☐	☐	☐	☐	☐	☐	☐	☐
Recognizes acquaintances; does not mistake strangers	☐	☐	☐	☐	☐	☐	☐	☐
Whereabouts occasionally confused	☐	☐	☐	☐	☐	☐	☐	☐
Date occasionally confused	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally does not recognize acquaintances or mistakes strangers	☐	☐	☐	☐	☐	☐	☐	☐
Whereabouts usually confused	☐	☐	☐	☐	☐	☐	☐	☐
Date usually confused	☐	☐	☐	☐	☐	☐	☐	☐
Whereabouts always confused	☐	☐	☐	☐	☐	☐	☐	☐
Has no idea of current date	☐	☐	☐	☐	☐	☐	☐	☐
Never recognizes acquaintances; always mistakes strangers	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								
Resocialization								
Participates in all activities	☐	☐	☐	☐	☐	☐	☐	☐
Participates in 6 or more activities	☐	☐	☐	☐	☐	☐	☐	☐
Participates in 3-5 activities	☐	☐	☐	☐	☐	☐	☐	☐
Participates in 2 activities	☐	☐	☐	☐	☐	☐	☐	☐
Participates in only 1 activity	☐	☐	☐	☐	☐	☐	☐	☐
Does not participate, cannot	☐	☐	☐	☐	☐	☐	☐	☐
Does not participate, will not	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								
Sociability								
Often joins group activities	☐	☐	☐	☐	☐	☐	☐	☐
Often joins games	☐	☐	☐	☐	☐	☐	☐	☐
Often initiates conversations	☐	☐	☐	☐	☐	☐	☐	☐
Often responds to conversations	☐	☐	☐	☐	☐	☐	☐	☐
Seldom joins group activities	☐	☐	☐	☐	☐	☐	☐	☐
Seldom joines games	☐	☐	☐	☐	☐	☐	☐	☐
Seldom initiates conversations	☐	☐	☐	☐	☐	☐	☐	☐
Seldom responds to conversations	☐	☐	☐	☐	☐	☐	☐	☐
Never joins group activities	☐	☐	☐	☐	☐	☐	☐	☐
Never joins games	☐	☐	☐	☐	☐	☐	☐	☐
Never initiates conversations	☐	☐	☐	☐	☐	☐	☐	☐
Never responds to conversations	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								

Elements of Assessment - Page 2	1st	2nd	3rd	4th	5th	6th	7th	8th
Cooperation								
Persuades others to join activities	☐	☐	☐	☐	☐	☐	☐	☐
Visits bedridden residents	☐	☐	☐	☐	☐	☐	☐	☐
Helps bedridden residents	☐	☐	☐	☐	☐	☐	☐	☐
Active in planning group activities	☐	☐	☐	☐	☐	☐	☐	☐
Helps with group activities	☐	☐	☐	☐	☐	☐	☐	☐
Joins groups when invited	☐	☐	☐	☐	☐	☐	☐	☐
Joins groups only when strongly urged	☐	☐	☐	☐	☐	☐	☐	☐
Refuses to join group activities	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								
Personality Traits and Moods								
Active	☐	☐	☐	☐	☐	☐	☐	☐
Cheerful	☐	☐	☐	☐	☐	☐	☐	☐
Considerate	☐	☐	☐	☐	☐	☐	☐	☐
Self-Sufficient	☐	☐	☐	☐	☐	☐	☐	☐
Talkative	☐	☐	☐	☐	☐	☐	☐	☐
Unselfish	☐	☐	☐	☐	☐	☐	☐	☐
Argumentative	☐	☐	☐	☐	☐	☐	☐	☐
Complaining	☐	☐	☐	☐	☐	☐	☐	☐
Critical	☐	☐	☐	☐	☐	☐	☐	☐
Irritable	☐	☐	☐	☐	☐	☐	☐	☐
Selfish	☐	☐	☐	☐	☐	☐	☐	☐
Bored	☐	☐	☐	☐	☐	☐	☐	☐
Clinging	☐	☐	☐	☐	☐	☐	☐	☐
Gloomy	☐	☐	☐	☐	☐	☐	☐	☐
Restless	☐	☐	☐	☐	☐	☐	☐	☐
Silent	☐	☐	☐	☐	☐	☐	☐	☐
Unresponsive	☐	☐	☐	☐	☐	☐	☐	☐
Withdrawn	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								
Games or Sports Interests								
Badminton	☐	☐	☐	☐	☐	☐	☐	☐
Bingo	☐	☐	☐	☐	☐	☐	☐	☐
Checkers	☐	☐	☐	☐	☐	☐	☐	☐
Chess	☐	☐	☐	☐	☐	☐	☐	☐
Cribbage	☐	☐	☐	☐	☐	☐	☐	☐
Other Card games:	☐	☐	☐	☐	☐	☐	☐	☐
Croquet	☐	☐	☐	☐	☐	☐	☐	☐
Dominos	☐	☐	☐	☐	☐	☐	☐	☐
Dice games	☐	☐	☐	☐	☐	☐	☐	☐
Horseshoes	☐	☐	☐	☐	☐	☐	☐	☐
Bowling	☐	☐	☐	☐	☐	☐	☐	☐
Shuffleboard	☐	☐	☐	☐	☐	☐	☐	☐
Other:								
Comments:								

Elements of Assessment - Page 3	1st	2nd	3rd	4th	5th	6th	7th	8th
Creative Activity Interests								
Needlework	☐	☐	☐	☐	☐	☐	☐	☐
Knitting	☐	☐	☐	☐	☐	☐	☐	☐
Sewing	☐	☐	☐	☐	☐	☐	☐	☐
Fancywork	☐	☐	☐	☐	☐	☐	☐	☐
Quilting	☐	☐	☐	☐	☐	☐	☐	☐
Woodcarving	☐	☐	☐	☐	☐	☐	☐	☐
Weaving	☐	☐	☐	☐	☐	☐	☐	☐
Beads	☐	☐	☐	☐	☐	☐	☐	☐
Outdoor gardening	☐	☐	☐	☐	☐	☐	☐	☐
Indoor gardening	☐	☐	☐	☐	☐	☐	☐	☐
Hobby shows	☐	☐	☐	☐	☐	☐	☐	☐
Collecting	☐	☐	☐	☐	☐	☐	☐	☐
Other:								
Comments:								
Spectator Activity Interests								
Concerts	☐	☐	☐	☐	☐	☐	☐	☐
Plays	☐	☐	☐	☐	☐	☐	☐	☐
Movies	☐	☐	☐	☐	☐	☐	☐	☐
Athletic events	☐	☐	☐	☐	☐	☐	☐	☐
Public events	☐	☐	☐	☐	☐	☐	☐	☐
Auto rides	☐	☐	☐	☐	☐	☐	☐	☐
Other:								
Comments:								
Musical & Related Interests								
Classical	☐	☐	☐	☐	☐	☐	☐	☐
Semi-classical	☐	☐	☐	☐	☐	☐	☐	☐
Modern-Classical	☐	☐	☐	☐	☐	☐	☐	☐
Modern-dance	☐	☐	☐	☐	☐	☐	☐	☐
Opera	☐	☐	☐	☐	☐	☐	☐	☐
Jazz	☐	☐	☐	☐	☐	☐	☐	☐
Other:								
Other Dancing:								
Playing an instrument (specify):								
Other Interests								
News, civic, world affairs	☐	☐	☐	☐	☐	☐	☐	☐
Newspapers, magazines, books	☐	☐	☐	☐	☐	☐	☐	☐
Radio	☐	☐	☐	☐	☐	☐	☐	☐
Television	☐	☐	☐	☐	☐	☐	☐	☐
Religious activities	☐	☐	☐	☐	☐	☐	☐	☐
Other:								
Comments:								

Elements of Assessment - Page 4	1st	2nd	3rd	4th	5th	6th	7th	8th
Participation In Games or Sports								
Always	☐	☐	☐	☐	☐	☐	☐	☐
Most of the time	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐
Never	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								
Participation In Creative Activities								
Always	☐	☐	☐	☐	☐	☐	☐	☐
Most of the time	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐
Never	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								
Participation In Spectator Activities								
Always	☐	☐	☐	☐	☐	☐	☐	☐
Most of the time	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐
Never	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								
Participation In Musical Activities								
Always	☐	☐	☐	☐	☐	☐	☐	☐
Most of the time	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐
Never	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								
Participation In Musical Activities								
Always	☐	☐	☐	☐	☐	☐	☐	☐
Most of the time	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐
Never	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								

Assessed by:

1. _____ **5.** _____

2. _____ **6.** _____

3. _____ **7.** _____

4. _____ **8.** _____

ACUTE CARE TRANSFER DOCUMENT CHECKLIST

COPIES SENT WITH RESIDENT (Check all that apply):

These documents should ALWAYS accompany patient:

- ☐ Resident Transfer Form
- ☐ Face Sheet
- ☐ Current Medication List or Current MAR
- ☐ Advance Directives
- ☐ Care limiting Orders
- ☐ Out of hospital DNR
- ☐ Bed hold policy

Send these documents IF INDICATED:

- ☐ SBAR/Nurse's Progress Note
- ☐ Most Recent History & Physical and any recent hospital discharge summary
- ☐ Recent MD/NP/PA Orders related to Acute Condition
- ☐ Relevant Lab Results
- ☐ Relevant X-Rays

PERSONAL BELONGINGS SENT WITH RESIDENT:

- ☐ Eyeglasses
- ☐ Hearing Aid
- ☐ Dental Appliance
- ☐ Other _____

Signature of ambulance staff accepting envelope _____

ADL FUNCTIONAL / RESTORATIVE RECORD

Name - Last First Middle | Attending Physician | Room / Bed

INSTRUCTIONS: Upon admission and quarterly (at a minimum) thereafter, identify the resident status in all areas listed. Unless otherwise specified, indicate the response number that best describes the resident.

	ASSESSMENT DATE:			
	__-__-____	__-__-____	__-__-____	__-__-____
A. MENTAL STATUS	**1**	**2**	**3**	**4**
1 - Oriented x 3 **4** - Oriented x 1 **2** - Oriented x 2 **5** - Disoriented	☐	☐	☐	☐
Comments:				
B. COMMUNICATION STATUS				
a. Normal **(Check all that apply)**	☐	☐	☐	☐
b. Aphasic	☐	☐	☐	☐
c. Slurred speech	☐	☐	☐	☐
d. Dysarthria/Apraxia	☐	☐	☐	☐
e. Lip reads/Signs	☐	☐	☐	☐
f. Communication board	☐	☐	☐	☐
g. Speech therapy	☐	☐	☐	☐
h. Language barrier	☐	☐	☐	☐
Comments:				

C. HEARING STATUS	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**
R-Right ear L-Left ear **1** - Adequate **3** - Poor **2** - Good with aid **4** - Deaf	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								

D. VISION STATUS	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**
R-Right eye L-Left eye **1** - Adequate **4** - Blind **2** - Good with glassess **5** - Prosthesis **3** - Poor	☐	☐	☐	☐	☐	☐	☐	☐
Comments:								

E. TRANSFERS / AMBULATION				
1 - Independent **2** - Set up only **3** - 1 Assist **4** - 2 Assist **5** - Dependent	**(Use codes from left column)**			
	a. Transfers	☐	☐	☐	☐
	b. Ambulation	☐	☐	☐	☐
	c. Bed mobility	☐	☐	☐	☐
	d. Positioning	☐	☐	☐	☐

E. TRANSFERS / AMBULATION (CONTINUED)	R	L	R	L	R	L	R	L
6 - Full **7** - Partial **8** - None	**(Use codes from left column)** **R - Right Leg L - Left Leg** Weight bearing ability	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

ADAPTIVE DEVICES				
a. Recliner/Gerichair	**(Check all that apply)** ☐	☐	☐	☐
b. Mattress (Code A-air / W-water / G-gel)	☐	☐	☐	☐
c. Trapeze	☐	☐	☐	☐
d. Pillows	☐	☐	☐	☐

MOBILITY DEVICES				
a. Gait belt	☐	☐	☐	☐
b. Mechanical lift	☐	☐	☐	☐
c. Cain	☐	☐	☐	☐
d. Walker	☐	☐	☐	☐
e. Wheelchair	☐	☐	☐	☐
f. Crutches	☐	☐	☐	☐

Comments:

F. PERSONAL GROOMING / DRESSING				
1 - Independent **2** - Needs assist **3** - Totally dependent **4** - OT **5** - PT	**(Use codes from left column)** a. Oral care ☐	☐	☐	☐
	b. Bath ☐	☐	☐	☐
	Type			
	c. Hair care ☐	☐	☐	☐
	d. Shaving ☐	☐	☐	☐

	UE	LE	UE	LE	UE	LE	UE	LE
e. Dressing (UE / LE)	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

G. TOILETING				
1 - Independent **2** - Limited assist **3** - Total assist	**(Use code from left column)** Toileting status ☐	☐	☐	☐

Comments:

G. TOILETING (cont'd)				
4 - Bedpan/Urinal **5** - Bedside commode **6** - Elevated toilet seat **(Use code from left column)** **Adaptive equipment used**	☐	☐	☐	☐
Comments:				

H. BOWEL/BLADDER FUNCTION				
1 - Continent **2** - Dribbles **3** - Incontinent **4** - Constipation **5** - Diarrhea **6** - Ostomy **7** - Catheter **8** - Retraining program				
(Use codes from above)				
a. Bowel status	☐	☐	☐	☐
b. Bladder status	☐	☐	☐	☐
Comments:				

I. EATING/FEEDING STATUS				
(Check all that apply)				
a. Independent	☐	☐	☐	☐
b. Minimal assistance	☐	☐	☐	☐
c. Needs encouragement	☐	☐	☐	☐
d. Total assistance	☐	☐	☐	☐
e. Tube fed	☐	☐	☐	☐
f. I.V. or hyperalimentation	☐	☐	☐	☐
g. Restorative feeding program	☐	☐	☐	☐
h. Requires adaptive equipment (Specify under comments)	☐	☐	☐	☐
Comments:				

J. DENTAL STATUS				
1 - Upper dentures **2** - Lower dentures **3** - Upper and lower dentures **4** - Own teeth **5** - Edentulous	☐	☐	☐	☐
Comments:				

K. RANGE OF MOTION/CONTRACTURES				
Check all that apply. *If items c, d, or e apply, identify location/joint in COMMENTS section.				
a. No contractures	☐	☐	☐	☐
b. Prone to contractures	☐	☐	☐	☐
c. *Contractures present	☐	☐	☐	☐
d. *Active ROM	☐	☐	☐	☐

K. RANGE OF MOTION/CONTRACTURES (CONTINUED)				
e. *Passive ROM	☐	☐	☐	☐
f. Physical/Occupational therapy	☐	☐	☐	☐
g. Hand cones	☐	☐	☐	☐
h. Positioning/support equipment	☐	☐	☐	☐

Comments:

L. RESTRAINTS/ENABLERS				
Check all that apply. If restraints or enablers are used, specify type under COMMENTS				
a. None used	☐	☐	☐	☐
b. Side rails - Night only	☐	☐	☐	☐
c. While up in chair/Wheelchair only	☐	☐	☐	☐
d. Continuous	☐	☐	☐	☐
e. Restraint reduction/Free program	☐	☐	☐	☐

Comments:

M. PRESSURE SORE RISK ASSESSMENT	SCORE	SCORE	SCORE	SCORE
Refer to most recent assessment	☐	☐	☐	☐

N. FALL RISK ASSESSMENT	SCORE	SCORE	SCORE	SCORE
Refer to most recent assessment	☐	☐	☐	☐

O. MOTIVATION TOWARD ADL RESTORATION				
1 - Good **2** - Fair **3** - Poor	☐	☐	☐	☐

	ASSESSMENT SIGNATURES/TITLES	DATE	SUMMARY/COMMENTS
1		__-__-____	
2		__-__-____	
3		__-__-____	
4		__-__-____	

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS: Complete examination procedure before making ratings. While conducting the examination, have them sit in a firm chair without arms. For all MOVEMENT ratings (sections A, B, and C) rate highest severity observed.

SCORING CODES: 0 = None 1 = Minimal/Normal 2 = Mild 3 = Moderate 4 = Severe

		ASSESSMENT DATES			
SECTION A. FACIAL AND ORAL MOVEMENTS		__-__-____	__-__-____	__-__-____	__-__-____
1.	**MUSCLES OF FACIAL EXPRESSION** e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing				
2.	**LIPS AND PERIORAL AREA** e.g., puckering, pouting, smacking				
3.	**JAW** e.g., biting, clenching, chewing, mouth opening, lateral movement				
4.	**TONGUE** Rate only increase in movement both in and out of mouth, NOTinability to sustain movement.				
SECTION B. EXTREMITY MOVEMENTS					
5.	**UPPER (ARMS, WRISTS, HANDS, FINGERS)** Include choreic movements, (i.e., rapid, objectively purposeless, irregular, spontaneous), athetoid movements (i.e., slow, irregular, complex, serpentine). Do **NOT** include tremor (i.e., repetitive, regular, rhythmic)				
6.	**LOWER (LEGS, KNEES, ANKLES, TOES)** e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot				
SECTION C. TRUNK MOVEMENTS					
7.	**NECK, SHOULDERS, HIPS** e.g., rocking, twisting, squirming, pelvic gyrations				
SECTION D. GLOBAL JUDGMENTS					
8.	**SEVERITY OF ABNORMAL MOVEMENTS (SUM of 1-7)**				
9.	**INCAPACITATION DUE TO ABNORMAL MOVEMENTS**				
10.	**AWARENESS OF ABNORMAL MOVEMENTS** Rate only the person's report 0 = No awareness 1 = Aware, no distress 2 = Aware, mild distress 3 = Aware, moderate distress 4 = Aware, severe distress				
SECTION E. DENTAL STATUS					
11.	**CURRENT PROBLEMS WITH TEETH AND/OR DENTURES**				
12.	**ARE DENTURES USUALLY WORN?**				

EVALUATOR SIGNATURES

Signature/Title _____ *Signature/Title* _____

Signature/Title _____ *Signature/Title* _____

INSTRUCTIONS FOR CONDUCTING EXAMINATION

Complete examination procedures before making actual movement ratings. The chair to be used in this examination should be firm and without arms.

A. FACIAL AND ORAL MOVEMENTS

Ask the person to open mouth. Observe tongue at rest within mouth. Do this twice.

Ask the person to protrude tongue. Observe abnormalities of tongue movement.

B. EXTREMITY MOVEMENTS

Flex and extend the person's left and right arms, one at a time. Note any rigidity.

Ask the person to extend both arms outstretched in front with palms down. Observe trunk, legs, and mouth.

Have the person walk a few paces, turn, and walk back to chair. Observe hands and gait. Do this twice.

Ask the person to tap thumb with each finger as rapidly as possible for 10 - 15 seconds with both left and right hand. Observe facial and leg movements.

C. TRUNK MOVEMENTS

Ask the person to stand up. Observe in profile all body areas.

Have the person sit in chair with hands on knees, legs slightly apart, and feet flat on floor. Observe entire body for movements.

Ask the person to sit with hands hanging unsupported. If male, between knees or if female in dress, hanging over knees. Observe hands and other body areas.

D. GLOBAL JUDGMENTS

Ask the person if he/she notices any movement in mouth, face, hands, or feet. If YES, ask to what extent they currently interfere with activities.

E. DENTAL STATUS

Remove any material from mouth.

Ask the person about current condition of teeth, i.e., partial, dentures. Do either bother them now?

Braden Risk Assessment Scale

NOTE: Bed and chairbound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Patients with established pressure ulcers should be reassessed periodically.

Resident Name: Room/Bed: Assessment Date:

Sensory Perception	**1. Completely Limited**	**2. Very Limited**	**3. Slightly Limited**	**4. No Impairment**	*Indicate Appropriate Numbers Below*
Ability to respond meaningfully to pressure- related discomfort	Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	☐
Moisture	**1. Constantly Moist**	**2. Very Moist**	**3. Occasionally Moist**	**4. Rarely Moist**	
Degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always, moist. Linen must be changed at least once a shift.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry. Linen only requires changing at routine intervals.	☐
Activity	**1. Bedfast**	**2. Chairfast**	**3. Walks Occasionally**	**4. Walks Frequently**	
Degree of physical activity	Confined to bed.	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	☐
Mobility	**1. Completely Immobile**	**2. Very Limited**	**3. Slightly Limited**	**4. No Limitations**	
Ability to change and control body position	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent though slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	☐
Nutrition	**1. Very Poor**	**2. Probably Inadequate**	**3. Adequate**	**4. Excellent**	
Usual food intake pattern	Does not make even slight changes in body or extremity position without assistance.	Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	☐

Friction and Shear	**1. Problem**	**2. Potential Problem**	**3. No Apparent Problem**		
Usual food intake pattern	Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		☐
NOTE: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers. (15 or 16 = low risk; 13 or 14 = moderate risk; 12 or less = high risk)				**Total Score:**	☐

Care Card

Room

Prefers

Congintion

Time of Rising ::

Time of HS ::

Diet

Fluids

Devices:

Hearing Aid

Dentures

Meal Assist

Eyeglasses

Footwear

Bed Mobility

Splints:

hand

Personal Care

leg

knee

Special Needs:

carrots

hand roll

Gerisleaves / longsleaves

Card **1** of

Room

Prefers

Continence:

Wears

RNP

Bladder

Bowel

Toileting Plan

Transfers:

WC Cushions

Safety Interventions:

Assist

Chair Position Devices

Bolsters

Device

Padded Mats

Mobility:

Bed Devices:

NS Mats

Assist

Side Rails

NS Mats Fr Toilet

Device

Winged Matress

NS Mats Other Loc

Bed Mobility:

Air Mat/Check Infl

Chair Alarm

Assist

Bed Alarm

Special Needs:

Other Alarm

Cognitive Assessment (MMSE)

Orientation

What is the (year) (season) (date) (day) (month)?

Where are we: (country) (city) (part of city) (number of flat/house) (name of street)?

Registration

Name three objects: one second to say each.
Then ask the patient to name all three after you have said them.
Give one point for each correct answer.
Then repeat them until he learns all three.
Count trials and record.

TRIALS

Attention and calculation

Serial 7s: one point for each correct.
Stop after five answers.
Alternatively spell 'world' backwards.

Recall

Ask for the three objects repeated above.
Give one point for each correct.

Language

Name a pencil and watch (two points).
Repeat the following: 'No ifs, ands or buts' (one point).
Follow a three-stage command: 'Take a paper in your right hand, fold it in half and put it on the floor' (three points).
Read and obey the following: Close your eyes (one point).
Write a sentence (one point).

Total Score

INSTRUCTIONS FOR ADMINISTRATION OF MINI MENTAL STATE EXAMINATION

Orientation

1. Ask the date. Then ask specifically for parts omitted, for example, 'Can you also tell me what season it is?' Score 1 point for each correct.
2. Ask in turn, 'Can you tell me the name of this place?' (town, country, etc). Score 1 point for each correct.

Registration

Ask the patient if you may test his or her memory. Then say the names of three unrelated objects, clearly and slowly, about one second for each. After you have said all three, ask him or her to repeat them. This first repetition determines the score (0-3) but keep saying them until he or she can repeat all three, up to six trials. If he or she does not eventually learn all three, recall cannot be meaningfully tested.

Attention and calculation

Ask the patient to begin with 100 and count backwards by 7. Stop after five subtractions (93, 86, 79, 72, 65). Score the total number of correct answers. If the patient cannot or will not perform this task, ask him or her to spell the word 'world' backwards. The score is the number of letters in correct order, eg dlrow 5, dlowr 3.

Recall

Ask the patient if he or she can recall the three words you previously asked him or her to remember. Score 0-3.

Language

Naming: Show the patient a wrist-watch and ask him or her what it is. Repeat for pencil. Score 0-2.

Repetition: Ask the patient to repeat the sentence after you. Allow only one trial. Score 0 or 1.

Three-stage command: Give the patient a piece of plain blank paper and repeat the command. Score 1 point for each part correctly executed.

Reading: On a blank piece of paper, print the sentence 'Close your eyes' in letters large enough for the patient to see clearly. Ask him or her to read it and do what it says. Score 1 point only if he or she actually closes his eyes.

Writing: Give the patient a blank piece of paper and ask him or her to write a sentence for you. Do not dictate a sentence, it is to be written spontaneously. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.

Copying: On a clean piece of paper, draw intersecting pentagons (as below), each side about one inch and ask him or her to copy it exactly as it is. All ten angles must be present and two must intersect to score 1 point. Tremor and rotation are ignored.

A score of 20 or less generally suggests dementia but may also be found in acute confusion, schizophrenia or severe depression. A score of less than 24 may indicate dementia in some patients who are well educated and who do not have any of the above conditions. Serial testing may be of value to demonstrate a decline in cognitive function in borderline cases.

Cornell Scale for Depression in Dementia

Location:

A. Mood-related signs

1. Anxiety (anxious expression, ruminations, worrying)
2. Sadness (sad expression, sad voice, tearfulness)
3. Lack of reactivity to pleasant events
4. Irriability (easily annoyed, short tempered)

B. Behavioral disturbances

5. Agitation (restlessness, handwriting, hairpulling)
6. Retardation (slow movements, slow speech, slow reactions)
7. Multiple physical complains (score 0 if gastrointestinal symptoms only)
8. Loss of interest, less involved in usual activities
   (score only if change occurred acutely - in less than one month)

C. Physical signs

9. Appetite loss (eating less than usual)
10. Weight loss (score 2 if greater than 5 lb in one month)
11. Lack of energy (fatigues easily, unable to sustain activities)
    (score only if change occurred acutely - in less than one month)

D. Cyclic functions

12. Diurnal variation on mood (symptoms worse in the morning)
13. Difficulty falling asleep (later than usual for this person)
14. Multiple awakenings during sleep
15. Early morning awakening (earlier than usual for this person)

E. Ideational disturbances

16. Suicide (feels life is not worth living, has suicidal wishes, or makes suicidal attempt)
17. Poor sef-esteem (self-blame, self-deprecation, feelings or failure)
18. Pessimism (antipacipation of worst)
19. Mood-congruent delusions (delusions of poverty, illness, or loss)

Total score: *

* - Not diagnostic of depression, but higher score indicate greater need of further evaluation.

Signature

Fall Risk Discipline Trigger

- Review these items at Start of Care and during follow-up assessment.
- Check any item below that is pertinent to the patient to initiate an evaluation.
- If unsure, call the respective discipline first to discuss patient's condition.
- Fall Risk: Patient 65 years or older and any asterisk (*) item.

NURSING

*Over 65 and at risk for fall	☐
Multiple medications	☐
New changed medications and/or medication management	☐
Needs patient/caregiver teaching re: Condition or Diagnosis	☐

PHYSICAL THERAPY

*Recent fall or at risk for falls	☐
*Problems with gait and/or balance	☐
*Weakness that limits upper and lower body function	☐
*Patient having problems with or not using ambulatory assist device(s) correctly	☐
Any pain that limits function, especially joint pain	☐
Any worsening from initial assessment in the patient's ability to:	☐
Bathe	☐
Transfer	☐
Ambulate	☐

OCCUPATIONAL THERAPY

*Upper extremity weakness that limits upper body function	☐
Needs assistive devices for bathing SAFELY	☐
Any worsening from initial assessment for upper body function of:	☐
Bathing	☐
Grooming	☐
Upper body dressing	☐
Lower body dressing	☐
Toileting	☐
Feeding/Eating	☐

SLP (SPEECH LANGUAGE PATHOLOGY)

Recent CVA	☐
Any Speech deficit from recent head injury	☐
Difficulty swallowing	☐

- [ ] Expressive aphasia
- [ ] Potential for aspiration
- [ ] Excessive coughing while eating
- [ ] Persistent congestion (like with recurrent pneumonia)

MEDICAL SOCIAL WORKER

- [ ] Financial difficulty, paying for meds
- [ ] Assistance with placement in another setting
- [ ] Home environment concerns
- [ ] Adult Protective Services

Staff Signature: _____ Date: __-__-____

Fall Risk Evaluation

INSTRUCTIONS: Evaluate the resident status in the eight clinical condition parameters listed below (A-H) by assigning the corresponding score which best describes the resident in the appropriate evaluation column. Add the column of numbers to obtain the Total Score. If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan.

PARAMETER	SCORE	RESIDENT STATUS/CONDITION	Date			
			__-__-____	__-__-____	__-__-____	__-__-____
A. LEVEL OF CONSCIOUSNESS/ MENTAL STATUS	**0**	**ALERT** - (oriented x 3) OR COMATOSE	☐	☐	☐	☐
	2	**DISORIENTED** x 3 at all times	☐	☐	☐	☐
	4	**INTERMITTENT CONFUSION**	☐	☐	☐	☐
B. HISTORY OF FALLS (Past 3 months)	**0**	**NO FALLS** in past 3 months	☐	☐	☐	☐
	2	**1 - 2** FALLS in past 3 months	☐	☐	☐	☐
	4	**3 OR MORE FALLS** in past 3 months	☐	☐	☐	☐
C. AMBULATION/ ELIMINATION STATUS	**0**	**AMBULATORY/CONTINENT**	☐	☐	☐	☐
	2	**CHAIR BOUND** - Assist with elimination	☐	☐	☐	☐
	4	**AMBULATORY/INCONTINENT**	☐	☐	☐	☐
D. VISION STATUS	**0**	**ADEQUATE** (with or without glasses)	☐	☐	☐	☐
	2	**POOR** (with or without glasses)	☐	☐	☐	☐
	4	**LEGALLY BLIND**	☐	☐	☐	☐
E. GAIT/BALANCE		To evaluate the resident's Gait/Balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway; and make a turn. If N/A, do not check any other boxes.				
	2	N/A - not able to perform function	☐	☐	☐	☐
	0	Gait/Balance normal	☐	☐	☐	☐
	1	Balance problem while standing	☐	☐	☐	☐
	1	Balance problem while walking	☐	☐	☐	☐
	1	Decreased muscular coordination	☐	☐	☐	☐
	1	Change in gait pattern when walking through doorway	☐	☐	☐	☐
	1	Gait Problems: Jerking, unstable when making turns, unsteady gait, shuffling gait	☐	☐	☐	☐
	1	Requires use of assistive devices (i.e., cane, w/c, walker, furniture)	☐	☐	☐	☐
F. SYSTOLIC BLOOD PRESSURE	**0**	**NO NOTED DROP** between lying and standing	☐	☐	☐	☐
	2	Drop **LESS THAN 20 mm Hg** between lying and stainding	☐	☐	☐	☐
	4	Drop **MORE THAN 20 mm Hg** between lying and standing	☐	☐	☐	☐
G. MEDICATIONS		Antipsychotics, Antianxiety Agents, Antidepressants, Hypnotics, Cardiovascular Medications, Diuretics, Narcotic Analgesics, Neuroleptics, Other Medications That Cause Lethargy or Confusion				
	0	**NONE** of these medications taken currently or within last 7 days	☐	☐	☐	☐

G. MEDICATIONS (Continued)	**2** **TAKES 1 - 2** of these medications currently and/or within last 7 days	☐	☐	☐	☐
	4 **TAKES 3 - 4** of these medications currently and/or within last 7 days	☐	☐	☐	☐
	1 If resident has had a change in medication and/or change in dosage in the past 5 days = score 1 additional	☐	☐	☐	☐

G. PREDISPOSING DISEASES	Circulatory/Heart, Neuromuscular/Functional, Orthopedic, Perceptual, Psychiatric/Cognitive, Infection, Pain/Headache, Fatigue/Weakness/Weight Loss, Vitamin D Deficiency, History of Falls				
	0 **NONE PRESENT**	☐	☐	☐	☐
	2 **1 - 2 PRESENT**	☐	☐	☐	☐
	4 **3 OR MORE PRESENT**	☐	☐	☐	☐

TOTAL SCORE	**Total score of 10 or above represents HIGH RISK**				

	SIGNATURE / DATE		SIGNATURE / DATE	
1		__-__-____	3	__-__-____
2		__-__-____	4	__-__-____

Fall Safety Checklist

***If No to any question, recommend remedy or assist patient with resolution. Document accordingly.**

EMERGENCY PLANS

- Are emergency numbers posted on or near the telephone? ☐
- Do you have access to a telephone if you fall or experience some other emergency which prevents you from standing and reaching a wall phone? ☐

ASSISTIVE EQUIPMENT

- In Use ☐
- If In Use, is equipment in good repair? ☐
- Is equipment properly fitting? ☐

FLOORS AND WALKWAYS

- Are lamp, extension, and telephone cords placed out of the flow of traffic? ☐
- Are all small rugs and runners slip-resistant? ☐
- Are hallways, passageways between rooms, and other heavy traffic areas well lit? ☐
- Are exits and passageways kept clear? ☐

STAIRS AND STEPS

- Are stairs well lighted? ☐
- Do the steps allow secure footing? ☐
- Are light switches located at both the top and bottom of the stairs? ☐
- Are steps even and of the same size and height? ☐
- Are the coverings on the steps in good condition? ☐
- Can you clearly see the edges of the steps? ☐
- Are stairways clear of stored items? ☐

KITCHEN

- Do you have a step stool which is stable and in good repair? ☐
- Are items within easy reach, so that you are not looking up to grasp? ☐

BATHROOM

Do bathtubs and showers have non-skid mats, abrasive strips, or surfaces that are not slippery? ☐

Do bathtubs and showers have at least one (preferably two) grab bars? ☐

Is a light switch located near the entrance to the bathroom? ☐

BEDROOM

Are lamps or light switches within reach of each bed? Are there nitelights? ☐

WALKWAYS

Are walkways free of cracks or uneven pavements, tree roots, shrubs or slippery surfaces? ☐

Is there adequate outside lighting near walkways? Are steps safe? Handrails? ☐

Staff Signature _____ Date __-__-____

Geriatric Depression Scale and Scoring

Resident Name: Room/Bed:

Assessment Date:

Please note: This test will only be scored correctly if you answer each one of the questions.
The 15 items below refer to how you have felt and behaved during the last week.

1. Are you basically satisfied with your life? ☐
2. Have you dropped many of your activities and interests? ☐
3. Do you feel that your life is empty? ☐
4. Do you often get bored? ☐
5. Are you in good spirits most of the time? ☐
6. Are you afraid that something bad is going to happen to you? ☐
7. Do you feel happy most of the time? ☐
8. Do you often feel helpless? ☐
9. Do you prefer to stay at home, rather than going out and doing new things? ☐
10. Do you feel you have more problems with memory than most? ☐
11. Do you think it is wonderful to be alive now? ☐
12. Do you feel pretty worthless the way you are now? ☐
13. Do you feel full of energy? ☐
14. Do you feel that your situation is hopeless? ☐
15. Do you think that most people are better off than you are? ☐

Total

About Scoring this Psychological Questionnaire

This quiz is scored by allocating 1 point to each 'depressive' answer, where the answer associated with depression is 'yes' for each question except for questions 1, 5, 7, 11, and 13.

Geriatric Depression Rating Scale Answers

Total score of: 15 (12 to 15, Severe Depression)

You appear to be suffering from severe depressive symptoms commonly associated with serious depressive disorders. You would likely benefit from the immediate attention of your physician or a trained mental health professional for further evaluation and a more accurate diagnosis and treatment.

Total score of: 11 (9 to 11, Moderate Depression)

You appear to be experiencing *some moderate depressive symptoms*, many of which are commonly found amongst the general population, but border on the possibility of a depressive episode. It is unclear whether or not you suffer these problems severely enough to need to seek further diagnosis and treatment.

Total score of: 7 (5 to 8, Mild Depression)

You appear to be experiencing some very *mild depressive symptoms*, most of which are commonly found amongst the general population. It is unclear whether or not you suffer these problems severely enough to need to seek further diagnosis and treatment.

Total score of: 1 (0 to 4, Normal Range)

Your score falls within the range of 0 to 4 and is in the range which suggests you do not appear to be experiencing any depressive symptoms at this time. If this changes, you may need to seek further diagnosis and treatment.

HAMILTON DEPRESSION INVENTORY

Resident: **Room/Bed:**

Assessment Date:

1a) In the past two weeks, how often have you been bothered by feeling depressed? (i.e., sad, blue, "down in the dumps")

- ☐ 0 Not at all or rarely
- ☐ 1 Occasionally
- ☐ 2 Often (about 1/2 the time)
- ☐ 3 Very often
- ☐ 4 Almost all of the time

1b) On average, how bad was the feeling of being depressed?

- ☐ 1 Mild
- ☐ 2 Moderate
- ☐ 3 Severe
- ☐ 4 Very Severe

1c) When you are feeling depressed, to what extent does your mood lift when something good happens to you?

- ☐ 0 My mood lifts significantly, and I feel better
- ☐ 1 My mood lifts a bit and I feel somewhat better
- ☐ 2 My mood lifts only minimally
- ☐ 3 My mood doesn't lift at all

1d) How often do you cry or feel like crying?

- ☐ 0 Rarely
- ☐ 1 Slightly more than usual for me
- ☐ 2 Quite a bit more than usual for me
- ☐ 3 Nearly all of the time

SCORE: ADD 1a + 1b + 1c + 1d = ***DIVIDE BY: 3.5 =***

QUESTION #1 TOTAL =

2) In the past two weeks, have you thought about suicide?

- ☐ 0 I have not had any thoughts about suicide
- ☐ 1 I feel like life is not worth living
- ☐ 2 I think about killing myself but have no plans
- ☐ 3 I think about killing myself and have a specific method or plan
- ☐ 4 I tried to kill myself in a way that I was sure would succeed

QUESTION #2 TOTAL =

3a) Have you noticed any change in your interest in or ability to enjoy your usual activities? (For example, your hobbies, work, social activities, family, or other leisure activities)

- ☐ 0 I still enjoy and am interested in my usual activities
- ☐ 1 I am somewhat less interested in or get less enjoyment from my usual activities
- ☐ 2 I am much less interested in or get less satisfaction from my usual activities
- ☐ 3 I get almost no pleasure out of any of my activities
- ☐ 4 I have lost ALL interest in and pleasure from my usual activities

3b) Have you noticed any change in your work performance? (Either at home, office, school, etc)

- ☐ 0 I work about as well as usual
- ☐ 1 I am less efficient, but I get most things done eventually
- ☐ 2 I have to push myself to get my usual tasks accomplished, and some things remain undone
- ☐ 3 I have to push myself very hard to do even simple tasks, like washing or getting dressed
- ☐ 4 I am unable to work or take care of myself

SCORE: ADD 3a + 3b = ***DIVIDE BY 2 =***

QUESTION #3 TOTAL =

4a) How often have you felt anxious or nervous over the past two weeks?

- ☐ 0 Not at all or rarely
- ☐ 1 Occasionally
- ☐ 2 Often
- ☐ 3 Very often
- ☐ 4 Almost all of the time

4b) On average, how bad was the feeling of anxiety or nervousness over the past two weeks?

- ☐ 1 Mild
- ☐ 2 Moderate
- ☐ 3 Severe
- ☐ 4 Very severe

SCORE: ADD 4a + 4b = ***DIVIDE BY 2 =***

QUESTION #4 TOTAL =

5a) Have you had less physical energy than usual to do things?

- ☐ 0 I have had as much energy as usual
- ☐ 1 I get tired more easily or have less energy than usual
- ☐ 2 I have almost no energy and feel tired almost all of the time

5a) Have you had less physical energy than usual to do things?

- ☐ 0 My muscles usually are not tense or achy
- ☐ 1 I am often bothered by tense or aching muscles
- ☐ 2 My muscles constantly ache or are very tense

SCORE: TAKE THE HIGHER SCORE OF 5a OR 5b =

QUESTION #5 TOTAL =

6) Do you feel helpless or incapable of getting everyday tasks done?

- ☐ 0 Not at all
- ☐ 1 Occasionally
- ☐ 2 Often
- ☐ 3 Almost constantly

QUESTION #6 TOTAL =

7) Over the past two weeks, how have you been feeling about yourself?

- ☐ 0 I feel OK about myself
- ☐ 1 I feel that I am somewhat inadequate
- ☐ 2 I feel somewhat worthless as a person
- ☐ 3 I feel that I am a worthless person
- ☐ 4 I feel I am totally rotten and worthless as a person

QUESTION #7 TOTAL =

8) How does the future look to you?

- ☐ 0 OK
- ☐ 1 I feel a bit discouraged about the future
- ☐ 2 I am somewhat discouraged, and things seem hopeless to me
- ☐ 3 I am very discouraged and do not think that things will ever get better
- ☐ 4 The future is totally hopeless for me, and I know that things will never get better

QUESTION #8 TOTAL =

9) Over the past 2 weeks, how often did you have difficulty making decisions?

- ☐ 0 Not at all or rarely
- ☐ 1 Occasionally
- ☐ 2 Often (about half the time)
- ☐ 3 Very often
- ☐ 4 Almost all of the time

QUESTION #9 TOTAL =

ADD TOTALS FROM #'S 1-9:

0-6.0	**Not depressed**
6.5-8.5	**Subclinical**
9.0-12.5	**Mild**
13.0-16.5	**Moderate**
17.0-20.5	**Moderate to severe**
21.0 +	**Severe**

Infection Risk Assesment

	Date				
Predisposing Factor					
None	☐	☐	☐	☐	☐
Recent Hospitilization	☐	☐	☐	☐	☐
Foley Cath	☐	☐	☐	☐	☐
Decreased Tissue Perfusion	☐	☐	☐	☐	☐
Immune Complications	☐	☐	☐	☐	☐
Decreased Nutrition	☐	☐	☐	☐	☐
Decreased Hygiene	☐	☐	☐	☐	☐
Environment	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
Signs & Symptoms					
Pain	☐	☐	☐	☐	☐
Pain Level 4 and Above	☐	☐	☐	☐	☐
Tenderness	☐	☐	☐	☐	☐
Heat at Site	☐	☐	☐	☐	☐
Red Streaks from Site	☐	☐	☐	☐	☐
Edema	☐	☐	☐	☐	☐
Purulent Drainage	☐	☐	☐	☐	☐
Temp > 100.4	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
Specify Site	☐	☐	☐	☐	☐
Culture					
None	☐	☐	☐	☐	☐
Strep	☐	☐	☐	☐	☐
Pseudomonas Aeruginosa	☐	☐	☐	☐	☐
Candida	☐	☐	☐	☐	☐
C. Diff	☐	☐	☐	☐	☐
E. Coli	☐	☐	☐	☐	☐
Klebsiella	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

Culture/Lab Results	☐	☐	☐	☐	☐	
MRSA	☐	☐	☐	☐	☐	

Outcome

Unscheduled Hospitalization	☐	☐	☐	☐	☐	
Unexpected Clinical Determinization	☐	☐	☐	☐	☐	
Expected Clinical Determination	☐	☐	☐	☐	☐	
Ineffective Therapy	☐	☐	☐	☐	☐	
Secondary Infection Development	☐	☐	☐	☐	☐	
Death Expected	☐	☐	☐	☐	☐	
Death Unexpected	☐	☐	☐	☐	☐	
Resolved with Treatment	☐	☐	☐	☐	☐	
Resolved without Treatment	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	

Signature / Date

1		__-__-____
2		__-__-____
3		__-__-____
4		__-__-____
5		__-__-____

Initial Interdisciplinary Evaluation

Resident Name Assessment Date

INITIAL NURSING EVALUATION

Admission Notes

Date of admission

Transported by

Accompanied by

Age Sex Weight Height

Vitals: T P Reg Irreg R BP

Attending physician notified? No Yes Date __-__-____ time ::

Diagnosis: Rehab: / Potential: Good Fair Poor

Date last chest x-ray or PPD __-__-____ Results for TB: Positive Negative

Identify Site on Diagram Below

General Skin Condition

Intact/good condition

Reddened Dry Moist

Cyanotic Ashen Oily

Pale Jaundiced

Warm Cold

Poor skin turgor

SPECIAL TREATMENTS AND PREVENTIVE MEASURES:

Skin Condition

Using the diagrams provided, indicate all body marks such as old/recent scars (surgical and other), bruises, discolorations, abrasions, stasis ulcers, pressure ulcers, or questionable markings. Indicate size, depth (in cms), color and drainage.

COMMENTS:

Allergies

Meds

Food

Other

Communication/Hearing Patterns

ABILITY TO HEAR: Adequate ☐ Impaired ☐ Deaf ☐

Absence of useful hearing device ☐ Use of hearing device ☐

MODE OF EXPRESSION: Speech: ☐

Clear ☐ Aphasic ☐

Dysphasic ☐ Signs/gestures/sounds ☐

Other ☐

Specify

Language(s) spoken:

ABLE TO UNDERSTAND/MAKE SELF UNDERSTOOD:

Always ☐ Usually ☐ Sometimes ☐ Rarely/never ☐

Vision Patterns

ABILITY TO SEE: Adequate ☐ Impaired ☐ Highly impaired ☐ Blind ☐

Device(s) used ☐

Specify

Continence

BLADDER: Continent ☐ Usually continent /dribbles ☐

Frequent incontinence ☐ Incontinent ☐

Appliance(s) used: No ☐ Yes ☐

Type

Time last voiding ::

BOWEL: Continent ☐ Usually continent ☐

Frequent incontinence/diarrhea ☐

Constipation ☐ Impactions ☐

Last bowel movement ::

Briefs used: No ☐ Yes ☐

Laxative used: No ☐ Yes ☐ Type

Enemas used: No ☐ Yes ☐ Type

Appliances used: No ☐ Yes ☐ Type

Uses: Toilet ☐ Urinal ☐ Bedpan ☐ Bedside commode ☐

Physical Functioning/Structural Problems

SELF-PERFORMANCE CODES:
0 = Independent 1 = Supervision 2 = Limited Assist 3 = Extensive Assist 4 = Dependent 8 = Activity Did Not Occur

SUPPORT CODES:
0 = No Assist 1 = Set-up only 2 = Assist 1 3 = Assist 2+

FUNCTION	SELF-PERFORMANCE	SUPPORT
BED MOBILITY		
TRANSFER		
LOCOMOTION		
DRESSING		
EATING		
TOILET USE		
PERSONAL HYGIENE		
BATHING		

BATHING METHOD: Tub ☐ Shower ☐ Bed bath ☐

TASK SEGMENTATION REQUIRED: No ☐ Yes ☐

WEIGHT BEARING:

Able to bear: Full weight ☐ Partial weight ☐ Non-weight bearing ☐

Wheelchair only ☐ Wheelchair, propels self ☐

SUPPORTIVE DEVICES USED:

Elastic hose ☐ Cane ☐ Walker ☐ Handrolls ☐

Specialty bed ☐ Sling ☐ Trapeze ☐

Other ☐ (specify)

RESTRAINTS USED: No ☐ Yes ☐ Type

Diagnosis:

Reason:

Effectiveness:

Disease Diagnoses/Health Conditions

Paralysis ☐ site

Contractures ☐ site, degree

Edema ☐ site, degree

Pain ☐ Frequency

Intensity

Location(s)

Persistent nausea/vomiting ☐ Specify

Shortness of breath ☐ Specify

Dizziness/vertigo ☐ Specify

Other:

Sleep Patterns

USUAL:

Bedtime :: Rising time ::

Nap time :: Nap time ::

Usual for resident ☐

Altered (specify below) ☐

INTERVENTION, if appropriate

Medications

Additional Comments

INITIAL NUTRITIONAL EVALUATION

Physical Characteristics

Sex: M ☐ F ☐ Height: Weight:

Usual weight: BMI: IBW:

Adjusted body weight:

Amputation: No ☐ Yes ☐

if yes, specify body part and adjust IBW

Recent weight change (specify):

Oral/Nutritional/Dental Status

Own teeth: Yes ☐ No ☐

Decay ☐ Tooth loss ☐ Gum Disease ☐ No teeth ☐

Mouth pain ☐ Specify

Dentures: ☐ Upper ☐ Lower ☐ Fit

Partial: ☐ Upper ☐ Lower ☐ Fit

Will not wear dentures/partials ☐

Problem Areas (explain as appropriate)

Chewing ☐

Comments:

Dysphagic ☐

Reason

Swollen lips/gums ☐

Comments:

Pockets food ☐

Comments:

Mouth pain ☐

Comments

Other (Specify)

Eating Ability

No assistance	☐	Voracious appetite	☐	Eats while walking	☐
Requires verbal cues	☐	Eats non-edible items	☐		
Fed by staff	☐	Eats fast	☐		
Eats with fingers	☐	Leaves table without eating	☐		
Self-help device needed	☐	Eats alone	☐		

Self-help device type

Other

Average % food consumed: 25% ☐ 50% ☐ 75% ☐ 100% ☐

Food Preferences/Intolerances

DIET ORDER

TEXTURE NEEDS

TUBE FEEDING

Can make food choices ☐ Unable to communicate needs/desires ☐

LOCATION OF MEALS: Dining room ☐ Specify

Room ☐ Specify

Portion

Bread

Cereal

Breakfast

Lunch

Dinner

Fluids

Snacks

Favorite foods

Best Meal

Ethnic/Religious food preferences

Dairy

Fruits/Vegetables

Breads/Cereals

Meat group

Other

CLINICAL DATA (see lab reports (if any) to compare results to normal values)

TEST DATE	LAB TEST	TEST RESULTS	TEST DATE	LAB TEST	TEST RESULTS
__-__-____	Hemoglobin (Hgb)		__-__-____	Creatinine	
__-__-____	Hematocrit (Hct)		__-__-____	Triglycerides (TRIG)	
__-__-____	Serum Albumin (Alb)		__-__-____	Cholesterol (CHOL)	
__-__-____	PreAlbumin (PreAlb)		__-__-____	Total Lymphocyte Count	
__-__-____	Transferrin (iron)		__-__-____	A1c	
__-__-____	Sodium (Na+)		__-__-____	Phosphorus	
__-__-____	Potassium (K+)		__-__-____	Magnesium	
__-__-____	Fasting blood sugar (Glucose or GLU)				
__-__-____	BUN				

ENERGY NEEDS

Needs _____cal cal _____ gm protein _____ mL fluid

calculated by _____ formula/method

Nourishment Needs: A.M. _____ P.M. _____ H.S. _____

Supplement Needs: _____

SOURCE OF INFORMATION (CHECK ALL THAT APPLY):

Resident ☐ Family member(s) ☐ Chart ☐ Nursing staff ☐

Completed by: _____ Date __-__-____

INITIAL ACTIVITY EVALUATION (Check all appropriate items. Elaborate when possible.)

PARTICIPATION IN ACTIVITIES

☐ New Admit: Anticipate resident attending _____ activities per day

☐ Resistant to participation in group activities

☐ Participates in independent activities, such as: _____

☐ Voices activity preferences

☐ Other pertinent information: _____

ACTIVITY PARTICIPATION LEVEL

☐ Able to attend group activities independently

- [ ] Requires reminding to attend activities
- [ ] Requires assistance to attend activities
- [ ] Anticipate active participant
- [ ] Anticipate passive participant
- [ ] Behavior is appropriate
- [ ] Behavior may be inappropriate at times. Explain:
- [ ] Other pertinent information:

SOCIALIZATION PATTERNS

- [ ] Comfortable being alone
- [ ] Likes to be with people
- [ ] Makes friends easily
- [ ] Has difficulty in making friends/shy
- [ ] Likes to stay in room
- [ ] Likes to be out of room
- [ ] Enjoys large groups
- [ ] Enjoys small groups
- [ ] Visits with family and friends
- [ ] Voices daily preferences
- [ ] Other pertinent information:

PSYCHOSOCIAL NEEDS

- [ ] Adjustment to placement
- [ ] Group interaction
- [ ] One to one interaction
- [ ] Intellectual stimulation
- [ ] Creativity
- [ ] Spiritual growth
- [ ] Responsibility
- [ ] Independence
- [ ] Sensory stimulation
- [ ] Leadership
- [ ] Security
- [ ] Privacy
- [ ] Other

ADAPTIVE EQUIPMENT USED

- ☐ Large print/Magnifying glass/Talking books
- ☐ Head set/Amplifying device
- ☐ Other:

Activity Staff Signature _____ Date __-__-____

SOCIAL SERVICE EVALUATION

Cognitive/Mental Status

- ☐ Forgetful
- ☐ Confused
- ☐ Short Attention Span
- ☐ Easily Distracted

Short Term Memory

- ☐ Good
- ☐ Fair
- ☐ Poor

Oriented To:

- ☐ Person
- ☐ Place
- ☐ Time
- ☐ Situation

Long Term Memory

- ☐ Good
- ☐ Fair
- ☐ Poor

Decision Making:

- ☐ Independent
- ☐ Needs assist in new situations
- ☐ Moderately impaired
- ☐ Severely impaired

Onset of memory problems

Comments

Mood/Behavior Problems

- ☐ Cooperative
- ☐ Friendly
- ☐ Helpful
- ☐ Resists care
- ☐ Verbally aggressive
- ☐ Physically aggressive

Anxious/fearful ☐ Suspiciousness ☐

Depressive symptoms ☐ Delusions ☐

Wanders ☐ _____ hours per day Hallucinations ☐

Mood swings ☐

Inappropriate behaviors

Comments

Personal Habits:

Smokes ☐ Uses alcohol ☐

Other ☐

Specify:

Comments:

PSYCHIATRIC HISTORY/ADJUSTMENT STATUS

Current psychiatric diagnosis: No ☐ Yes ☐

Specify

PASARR screen indicated: No ☐ Yes ☐

Specify

Currently taking psychoactive medications: No ☐ Yes ☐

if Yes list drug, reason taken, result

Present adjustment issues:

Resident Relationships

Family visits: No ☐ Yes ☐

How often _____ Resident reaction _____

Friends: No ☐ Yes ☐

How often _____ Resident reaction _____

Community/Church visits: No ☐ Yes ☐

How often _____ Resident reaction _____

Adjustment to roommate:

Adjustment to staff:

Recent changes in family (divorce, death, moves):

Who assists with personal needs?

Discharge

Respite ☐ Short term ☐ Long term/potential discharge ☐ Long term/no discharge ☐

Staff Representative Signature _____ Date __-__-____

Montreal Cognitive Assessment (MoCA)

Resident: **Room/Bed:**

Assessment Date:

Administration and Scoring Instructions

The Montreal Cognitive Assessment (MoCA) was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. Time to administer the MoCA is approximately 10 minutes. The total possible score is 30 points; a score of 26 or above is considered normal.

1. Alternating Trail Making:

Administration: The examiner instructs the subject: *"Please draw a line, going from a number to a letter in ascending order. Begin here [point to (1)] and draw a line from 1 then to A then to 2 and so on. End here [point to (E)]."*
Scoring: Allocate one point if the subject successfully draws the following pattern:
1 - A - 2 - B - 3 - C - 4- D - 5 - E, without drawing any lines that cross. Any error that is not immediately self-corrected earns a score of 0.

2. Visuoconstructional Skills (Cube):

Administration: The examiner gives the following instructions, pointing to the cube: *"Copy this drawing as accurately as you can, in the space below".*
Scoring: One point is allocated for a correctly executed drawing.
• Drawing must be three-dimensional
• All lines are drawn
• No line is added
• Lines are relatively parallel and their length is similar (rectangular prisms are accepted)
A point is not assigned if any of the above-criteria are not met.

3. Visuoconstructional Skills (Clock):

Administration: Indicate the right third of the space and give the following instructions: *"Draw a clock. Put in all the numbers and set the time to 10 past 11".*
Scoring: One point is allocated for each of the following three criteria:
• Contour (1 pt.): the clock face must be a circle with only minor distortion acceptable (e.g., slight imperfection on closing the circle);
• Numbers (1 pt.): all clock numbers must be present with no additional numbers; numbers must be in the correct order and placed in the approximate quadrants on the clock face; Roman numerals are acceptable; numbers can be placed outside the circle contour;
• Hands (1 pt.): there must be two hands jointly indicating the correct time; the hour hand must be clearly shorter than the minute hand; hands must be centred within the clock face with their junction close to the clock centre.
A point is not assigned for a given element if any of the above-criteria are not met.

4. Naming:

Administration: Beginning on the left, point to each figure and say: *"Tell me the name of this animal".*
Scoring: One point each is given for the following responses:
(1) lion
(2) rhinoceros or rhino
(3) camel or dromedary.

5. Memory:

Administration: The examiner reads a list of 5 words at a rate of one per second, giving the following instructions: *"This is a memory test. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn't matter in what order you say them".*
Mark a check in the allocated space for each word the subject produces on this first trial. When the subject indicates that (s)he has finished (has recalled all words), or can recall no more words, read the list a second time with the following instructions: *"I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time."* Put a check in the allocated space for each word the subject recalls after the second trial.
At the end of the second trial, inform the subject that (s)he will be asked to recall these words again by saying, *"I will ask you to recall those words again at the end of the test."*
Scoring: No points are given for Trials One and Two.

6. Attention:

Forward Digit Span: Administration: Give the following instruction: *"I am going to say some numbers and when I am through, repeat them to me exactly as I said them".* Read the five number sequence at a rate of one digit per second.

Backward Digit Span: Administration: Give the following instruction: *"Now I am going to say some more numbers, but when I am through you must repeat them to me in the backwards order."* Read the three number sequence at a rate of one digit per second.

Scoring: Allocate one point for each sequence correctly repeated, (N.B.: the correct response for the backwards trial is 2-4-7).

Vigilance: Administration: The examiner reads the list of letters at a rate of one per second, after giving the following instruction: *"I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand".*

Scoring: Give one point if there is zero to one errors (an error is a tap on a wrong letter or a failure to tap on letter A).

Serial 7s: Administration: The examiner gives the following instruction: *"Now, I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop."* Give this instruction twice if necessary.

Scoring: This item is scored out of 3 points. Give no (0) points for no correct subtractions, 1 point for one correction subtraction, 2 points for two-to-three correct subtractions, and 3 points if the participant successfully makes four or five correct subtractions. Count each correct subtraction of 7 beginning at 100. Each subtraction is evaluated independently; that is, if the participant responds with an incorrect number but continues to correctly subtract 7 from it, give a point for each correct subtraction. For example, a participant may respond "92 – 85 – 78 – 71 – 64" where the "92" is incorrect, but all subsequent numbers are subtracted correctly. This is one error and the item would be given a score of 3.

7. Sentence repetition:

Administration: The examiner gives the following instructions: *"I am going to read you a sentence. Repeat it after me, exactly as I say it [pause]:* ***I only know that John is the one to help today."*** Following the response, say: ***"Now I am going to read you another sentence. Repeat it after me, exactly as I say it [pause]: The cat always hid under the couch when dogs were in the room."***

Scoring: Allocate 1 point for each sentence correctly repeated. Repetition must be exact. Be alert for errors that are omissions (e.g., omitting "only", "always") and substitutions/additions (e.g., "John is the one who helped today;" substituting "hides" for "hid", altering plurals, etc.).

8. Verbal fluency:

Administration: The examiner gives the following instruction: *"Tell me as many words as you can think of that begin with a certain letter of the alphabet that I will tell you in a moment. You can say any kind of word you want, except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix, for example, love, lover, loving. I will tell you to stop after one minute. Are you ready? [Pause] Now, tell me as many words as you can think of that begin with the letter F. [time for 60 sec]. Stop."*

Scoring: Allocate one point if the subject generates 11 words or more in 60 sec. Record the subject's response in the bottom or side margins.

9. Abstraction:

Administration: The examiner asks the subject to explain what each pair of words has in common, starting with the example: *"Tell me how an orange and a banana are alike".* If the subject answers in a concrete manner, then say only one additional time: *"Tell me another way in which those items are alike".* If the subject does not give the appropriate response (fruit), say, *"Yes, and they are also both fruit."* Do not give any additional instructions or clarification. After the practice trial, say: *"Now, tell me how a train and a bicycle are alike".* Following the response, administer the second trial, saying: *"Now tell me how a ruler and a watch are alike".* Do not give any additional instructions or prompts.

Scoring: Only the last two item pairs are scored. Give 1 point to each item pair correctly answered.
The following responses are acceptable:

Train-bicycle = means of transportation, means of travelling, you take trips in both;
Ruler-watch = measuring instruments, used to measure.

The following responses are **not** acceptable:

Train-bicycle = they have wheels;
Ruler- watch = they have numbers.

10. Delayed recall:

Administration: The examiner gives the following instruction: *"I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember."* Make a check mark (*V*) for each of the words correctly recalled spontaneously without any cues, in the allocated space.

Scoring: Allocate 1 point for each word recalled freely **without any cues**.

Optional:

Following the delayed free recall trial, prompt the subject with the semantic category cue provided below for any word not recalled. Make a check mark (*V*) in the allocated space if the
subject remembered the word with the help of a category or multiple-choice cue. Prompt all non-recalled words in this manner. If the subject does not recall the word after the category cue, give him/her a multiple choice trial, using the following example instruction, *"Which of the following words do you think it was, NOSE, FACE, or HAND?"*
Use the following category and/or multiple-choice cues for each word, when appropriate:

FACE: category cue: part of the body	multiple choice: nose, face, hand
VELVET: category cue: type of fabric	multiple choice: denim, cotton, velvet
CHURCH: category cue: type of building	multiple choice: church, school, hospital
DAISY: category cue: type of flower	multiple choice: rose, daisy, tulip
RED: category cue: a color	multiple choice: red, blue, green

Scoring: No points are allocated for words recalled with a cue. A cue is used for clinical information purposes only and can give the test interpreter additional information about the type of memory disorder. For memory deficits due to retrieval failures, performance can be improved with a cue. For memory deficits due to encoding failures, performance does not improve with a cue.

11. Orientation:

Administration: The examiner gives the following instructions: *"Tell me the date today"*. If the subject does not give a complete answer, then prompt accordingly by saying: *"Tell me the [year, month, exact date, and day of the week]."* Then say: *"Now, tell me the name of this place, and which city it is in."*

Scoring: Give one point for each item correctly answered. The subject must tell the exact date and the exact place (name of hospital, clinic, office). No points are allocated if subject makes an error of one day for the day and date.

TOTAL SCORE: Sum all subscores listed on the right-hand side. Add one point for an individual who has 12 years or fewer of formal education, for a possible maximum of 30 points. A final total score of 26 and above is considered normal.

Montreal Cognitive Assessment (MoCA)

Resident | Room/Bed

Education | Assessment Date

Sex | DOB

VISUOSPATIAL / EXECUTIVE — POINTS

1. **2.** **Copy Cube** **3.** **Draw CLOCK (Ten past elevent)**

Contour ☐

Numbers ☐

Hands ☐

☐ ☐ ☐

NAMING — POINTS

4.

☐ ☐ ☐

MEMORY — POINTS

5. Read list of words, subject must repeat them.
Do 2 trials, even if 1st trial is successful.
Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial	☐	☐	☐	☐	☐
2nd trial	☐	☐	☐	☐	☐

No Points

ATTENTION — POINTS

6. Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order ☐ 2 1 8 5 4

Subject has to repeat them in the backward order ☐ 7 4 2

Read list of letters. The subject must tap with his hand at each letter A. No points if >= 2 errors

☐ F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

Serial 7 subtraction starting at 100

☐ 93 ☐ 86 ☐ 79 ☐ 72 ☐ 65

4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

LANGUAGE — POINTS

7. Repeat : I only know that John is the one to help today. ☐

The cat always hid under the couch when dogs were in the room. ☐

8. Fluency / Name maximum number of words in one minute that begin with the letter F ☐ (N >= 11 words)

ABSTRACTION — POINTS

9. Similarity between e.g. banana - orange = fruit ☐ train – bicycle ☐ watch - ruler

DELAYED RECALL							POINTS
10.	Has to recall words **WITH NO CUE**	FACE ☐	VELVET ☐	CHURCH ☐	DAISY ☐	RED ☐	
Optional	Category cue	☐	☐	☐	☐	☐	
	Multiple choice cue	☐	☐	☐	☐	☐	

ORIENTATION							POINTS
11.	☐ Date	☐ Month	☐ Year	☐ Day	☐ Place	☐ City	

TOTAL	POINTS
Normal >= 26 / 30 Add 1 point if = 12 yr edu	

Non-Pressure Skin Condition Report

Resident Name

Assessment Date

DIRECTIONS: Fill in the appropriate boxes and spaces. *Use one form for each skin condition.

IDENTIFY SITE ON DIAGRAM BELOW

DATE FIRST OBSERVED: __-__-____

SITE /LOCATION: (Indicate on body form)

Surgical	☐	Non-Surgical	☐
Skin Tear	☐	Abrasion	☐
Venous/Stasis Ulcer	☐	Bruise	☐
Arterial Ulcer	☐	Diabetic	☐
Other	☐		

(specify)

DATE __-__-____

SIZE IN CM (LENGTH X WIDTH)

DEPTH (cm)

EXUDATE TYPE		**EXUDATE AMOUNT**			**ODOR**		**WOUND BED**	
None	☐	None	☐		None	☐	Normal for Skin	☐
Serous	☐	Scant	☐		Slight	☐	Epithelial Tissue	☐
Serosan-guineous	☐	Small	☐		Moderate	☐	Granulation Tissue	☐
Purulent	☐	Moderate	☐	Tunneling (cm)	Foul	☐	Slough	☐
		Large	☐				Black/Brown (eschar)	☐
		Copious	☐	Undermining (cm)				

SURROUNDING SKIN COLOR

- Normal for Skin ☐
- Pink ☐
- Bright Red ☐
- White/Gray Pallor ☐
- Dk Red/Purple ☐
- Black/Brown ☐

SURROUNDING TISSUE / WOUND EDGES

- Normal for Skin ☐
- Peripheral ☐
- Tissue Edema ☐
- Maceration ☐
- Hardness/Induration ☐
- Rolled Edges ☐

COMMENTS:

SIGNATURE

CULTURE SENT

- Yes ☐
- No ☐

PROGRESS

- Improved ☐
- Not Changed ☐
- Deteriorated ☐
- Healed ☐

TREATMENT

- Continue Treatment ☐
- Treatment Changed ☐

Date Physician Notified: __-__-____

Date Family Notified: __-__-____

Date Dietary Notified: __-__-____

Plan of Care Updated: Yes ☐ No ☐

Pain: Is resident experiencing pain related to wound?

Yes – See Pain Flow Sheet ☐ No ☐

Nutrition Assessment

Name **Rm#** **Assess Type:**

Physycian **Medical Record #**

Admission Date **DOB** **Age** **Sex**

Asessment Date **Capacity** ☐ **Incapacity** ☐

Advance directive: **Safe Harbor Level:**

Diagnosis:

Ht (in) **Date** __-__-____ **Wt (lb)** **Date** __-__-____ **Wt (kg)**

Usual Body wt range

BMI **IBW** **Weight History**

Significant Change (#) % days Gain ☐ Loss ☐

Current Diet / TF Order

Food Allergies / Intolerances

Supplements / Snacks

Adaptive Eating Devices

Meal Intake Average %

Swallowing ability **Chewing ability**

Able to feed self

Dentition: Natural Dentition Condtion

Dentures: Fit Worn Comments

GI Symptoms: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

Activity Level

Edema: Location:

Pertinent Medications:

Labs / Date __-__-____ **Albumin** **Glucose** **HgbA1c** **BUN**

Creat **Na+** **K+** **Hgb** **Hct** **MCV**

Other:

Skin Status: Intact ☐ Pressure Ulcer / Non-healing wound

Comments:

Bladder Function **Bowel Function**

Resident statement / reports / observations:

Beverages offered with meals cups

Estimated Nutritional Needs: kcal/day gms Pro/day (g/kg)

ml Fluid/day (ml/kg)

Comments:

Signature Date __-__-____

RD Signature Date __-__-____

Physician Signature Date __-__-____

PAIN EVALUATION

Resident - Last First Middle | Attending Phsycian | Room / Bed

GENERAL INFORMATION

Does the resident have any diagnosis(es) which would give reason to believe he/she would be in pain? ☐ Yes ☐ No

If yes, describe cause, origin of pain, radiation of pain, and prior treatment:

Ask resident: *"**Have you had pain or hurting at any time** in the last 5 days?"* ☐ Yes ☐ No

If yes, date of pain onset: __-__-____

As the patient describes it, what does the pain feel like? (check all that apply.)

☐ Aching ☐ Heavy ☐ Tender ☐ Splitting ☐ Tiring ☐ Exhausting ☐ Throbbing ☐ Shooting ☐ Stabbing

☐ Sharp ☐ Cramping ☐ Hot/Burning ☐ Tingling ☐ Other:

Additional symptoms associated with pain (e.g., nausea, anxiety):

Pain is increased by (describe circumstances or activities):

Any language and/or cultural barriers: ☐ Yes ☐ No If yes, explain:

Times when pain is worse: ☐ Early morning (pre-dawn) ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

PAIN LOCATION/TYPE/FREQUENCY/INTENSITY/DURATION

If the resident is able, identify pain type(s) and locations and record below. Label sites as A, B, C, D. Code pain type, frequency and intensity/duration as applicable. If resident is able to interview, use Wong-Baker, if not, use PAINAD.

TYPE	SITE A	SITE B	SITE C	SITE D
Code: I = Internal; **A** = Acute; **E** = External; **C** = Chronic				

FREQUENCY	SITE A	SITE B	SITE C	SITE D
Ask resident: ***"How much of time have you experienced pain or hurting** over last 5 days?"*				

1. Almost constantly
2. Frequently
3. Occasionally
4. Rarely
9. Unable to answer

WONG-BAKER

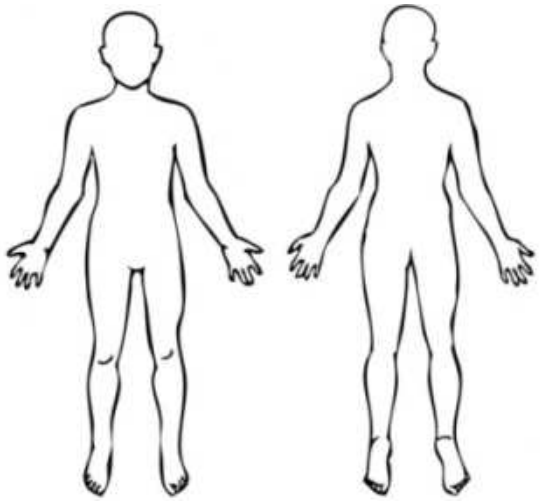
Ask resident: *"Please rate the intensity of your worst pain over the last 5 days, with 0 being no pain and 10 as the worst pain you can imagine."*

Wong-Baker FACES Pain Rating Scale

NO HURT	HURTS LIITLE BIT	HURTS LIITLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORSE

No Pain — Moderate Pain — Most Possible Pain

	SITE A	SITE B	SITE C	SITE D
At Present	. .	. .	. .	. .
1 Hour After Medication	. .	. .	. .	. .
3 Hours After Medication	. .	. .	. .	. .
Worst It Gets	. .	. .	. .	. .
Best It Gets	. .	. .	. .	. .



PAINAD: Score each row and total				
	0	1	2	Score
Breathing Independent of Vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations	☐
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	☐
Facial Expression	Smiling, or inexpressive	Sad, Frightened, Frowning	Facial grimacing	☐
Body Language	Relaxed	Tense, Distressed pacing, Fidgeting	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out.	☐
Consolability	No need to console	Unable to console, distract or reassure.	Unable to console, distract or reassure.	☐
			TOTAL	☐

PAIN EFFECT ON FUNCTION

Has the resident had any of the following changes in daily activities or habits? ☐ Participation in activities

☐ Inability to perform ADL's ☐ Insomnia ☐ Other sleep disturbances ☐ Loss of appetite/weight loss

☐ Constipation ☐ Incontinence ☐ Decreased ability to concentrate ☐ Withdrawal from activities or relationships

☐ Ability to focus, concentrate ☐ Decrease/increase in physical/social activity

☐ Changes in mood/emotions (e.g., anger, crying, depressed, etc.)

NONVERBAL / NONCOGNITIVE SIGNS OF PAIN

Check Yes or No for each of the following nonverbal/noncognitive signs which could indicate the presence of pain.

FACIAL EXPRESSIONS

☐ Grimacing/distorted face
☐ Clenched jaw/teeth
☐ Frowning/scowling
☐ Tightly shut lips
☐ Glazed eyes/tearing
☐ Wrinkled brow
☐ Turned down mouth
☐ Fright

VOCALIZATIONS

☐ Moaning
☐ Grunting
☐ Gasping
☐ Crying/whimpering
☐ Screaming
☐ Cursing

BODY ACTIONS/OBSERVED BEHAVIORS

☐ Thrashing/rocking
☐ Pounding
☐ Biting
☐ Pallor
☐ Threatening gestures
☐ Rubbing body parts
☐ Altered gait/posture/limping
☐ Strenuous or altered breathing
☐ Increased vital signs
☐ Knees pulled up into abdomen
☐ Fidgeting/irritability
☐ Pacing
☐ Perspiration
☐ Clenched fists
☐ Increased hand/finger movements
☐ Wringling of hands
☐ Striking out at others
☐ Depressed mood

RELIEF OF PAIN

Pain is relieved by (check all that apply): ☐ Medication ☐ Deep Relaxation ☐ Frequent Position Changes

☐ Heat ☐ Cold ☐ Massage ☐ Meditation ☐ Music ☐ Visual Imagery ☐ Enemas ☐ Diversional Activity

☐ Distraction ☐ None of Above ☐ Other (specify):

RELIEF OF PAIN (CONTINUED)

Any adverse consequences of interventions? ☐ Yes ☐ No

If yes, explain:

What is the resident's acceptable pain level: ☐ Unable to express

Is the resident on a scheduled pain regimen? ☐ Yes ☐ No

If yes, pain medication(s) in use:

Does the resident receive a PRN medication? ☐ Yes ☐ No

If yes, pain medication(s) in use:

Is pain medication effective: ☐ Yes ☐ No

Time elapsed until pain relief:

CONCLUSION

☐ No pain, intervention is not necessary. Re-assess quarterly or with onset of pain

☐ Pain management intervention is necessary, refer to resident plan of care

☐ Change in intervention, refer to resident plan of care

Interdisciplinary Team (IDT) Progress Note:

Signature: Date: __-__-____

Signature: Date: __-__-____

PRESSURE ULCER RISK EVALUATION

INSTRUCTIONS: Evaluate the resident status in the eight clinical condition parameters (A-H listed below) by assigning the corresponding score that best describes the resident in the appropriate evaluation column. Add the column of numbers to obtain the Total Score. If the total score is 8 or greater, the resident should be considered at HIGH RISK for skin breakdown and a prevention protocol should be initiated immediately.

			EVALUATION DATE	__-__-____	__-__-____	__-__-____	__-__-____
PARAMETER	**SCORE**	**RESIDENT STATUS/CONDITION**	**1**	**2**	**3**	**4**
A. LEVEL OF CONSCIOUSNESS/ MENTAL STATUS	0	**ALERT** - oriented x 3	☐	☐	☐	☐
	1	**LETHARGIC** - some disorientation, slow to respond				
	2	**SEMI-COMATOSE** - responds to verbal or painful stimuli				
	3	**COMATOSE** - persistent vegetative state/no discernable consciousness				
B. AMBULATION AND MOBILITY	0	**INDEPENDENT** - requires only supervision	☐	☐	☐	☐
	1	**LIMITED ASSISTANCE** - requires minimal physical assistance for ambulation or transfers				
	2	**CHAIRFAST** - non-ambulatory. Transfer requires assist and/or physical restraints				
	3	**BEDFAST** - total dependence. Spends 75% of time in bed and/or CONTRACTURES				
C. INCONTINENCE - BOWEL AND BLADDER	0	**CONTINENT**	☐	☐	☐	☐
	1	**OCCASIONALLY INCONTINENT** - 2 or less incidents/24 hrs. and occasional diarrhea/constipation				
	2	**USUALLY INCONTINENT** - 2 or more inciddents/24 hrs. (urine)				
	3	**INCONTINENT** - no control; constant diarrhea				
D. NUTRITION AND WEIGHT STATUS	0	**EXCELLENT** - eats 75 - 100% of meals OR weight within normal range or above IBW	☐	☐	☐	☐
	1	**GOOD** - eats 50 - 75% of meals OR less than 5% underweight				
	2	**FAIR** - eats 25 - 50% if meals OR more than 5% underweight				
	3	**POOR** - eats less than 25% of meals OR more than 10% underweight				
E. FLUID INTAKE	0	**2000mL** or more daily	☐	☐	☐	☐
	1	**1000 - 2000mL** daily				
	2	**500 - 1000mL** daily				
	3	**LESS THAN 500mL** daily				
F. PRESENCE OF EDEMA	0	**NONE PRESENT**	☐	☐	☐	☐
	1	**1+ PRESENT**				
	2	**2+ PRESENT**				
	3	**3-4+ PRESENT**				
G. MEDICATIONS (Chemotherapy, Stroids, Analgetics, Hypnotics, Psyhoactives)	0	**NONE PRESENT**	☐	☐	☐	☐
	1	**1+ PRESENT**				
	2	**2+ PRESENT**				
	3	**3-4+ PRESENT**				
H. PREDISPOSING DISEASES (DM, MS, CA, CVA, Vascular Disease, Blood Flow Impairment, Anemia, ESRD, Thyroid Disease, Generalized Atherosclerosis, Lower Extremity Arterial Insufficiency)	0	**NONE PRESENT**	☐	☐	☐	☐
	1	**1+ PRESENT**				
	2	**2+ PRESENT**				
	3	**3-4+ PRESENT**				
TOTAL SCORE	**Total score of 8 or above represents HIGH RISK**					

SIGNATURE / DATE		**SIGNATURE / DATE**	
1	__-__-____	**4**	__-__-____
2	__-__-____	**3**	__-__-____

Name	**Last**	**First**	**Midle**	**Attending Physician**	**RecNo**	**Room / Bed**

Resident Care Card

__-__-____

Resident Name:

Cognition

Dentures
- Upper ☐
- Lower ☐
- Both ☐
- N/A ☐

Hearing Aid
- Right ☐
- Left ☐
- Both ☐
- N/A ☐

Up for Bfst. ☐

Glasses ☐

Laundry

Transfer
- Independent ☐
- Assist of 1 ☐
- Assist of 2 ☐
- Mechanical Lift ☐
- Other

Personal Care
- Independent ☐
- Assist of 1 ☐
- Assist of 2 ☐
- Total Care ☐
- Other

Elimination IC Garment
- Underwear ☐
- White ☐
- Green ☐
- Blue ☐
- Peach ☐
- Disps. Brief ☐
- Other

Mobility

Fluids

Diet

Continence
- Bladder C ☐ I ☐
- Bowel C ☐ I ☐

WC/Chair Cushions
- gel ☐
- roho ☐
- gel foam ☐
- wedge ☐
- lateral supports ☐

RNP
- Yes ☐
- No ☐

Meal Assist
- Independent/Setup ☐
- Cues/Supervision ☐
- Limited Assist. ☐
- Extensive Assist. ☐
- Dependent ☐

Medical DX
- CVA ☐
- Cardiac ☐
- Dementia ☐
- HTN ☐
- DM ☐
- Osteoporosis ☐
- Arthritits ☐
- Water Pill ☐
- Blood Thinner ☐
- Other

Splints

hand	rt ☐	lt ☐	both ☐	
leg	rt ☐	lt ☐	both ☐	
knee	rt ☐	lt ☐	both ☐	
ankle	rt ☐	lt ☐	both ☐	
Carrots	rt ☐	lt ☐	both ☐	
hand roll	rt ☐	lt ☐	both ☐	

Bed Devices

Side Rails
- 0 ☐ 1/4 rt ☐ 1/4 lt ☐ 1/4 both ☐
- 1/2 rt ☐ 1/2 lt ☐ 1/2 both ☐
- full rt ☐ full lt ☐ full both ☐

Bolsters
- 0 ☐
- rt ☐
- lt ☐
- both ☐

Padded Mats
- 0 ☐
- rt ☐
- lt ☐
- both ☐

Non Skid Mat
- 0 ☐
- rt of bed ☐
- lt of bed ☐
- both sides of bed ☐
- bathroom ☐

Special Needs

Resident Care Sheet

ADL's

Mobility

Saftey Device

Toileting

Eating

Resident Summary

Resident Name: Date:

Admission ☐ Re-admission ☐ Significant Change ☐ Other

INSTRUCTIONS: Check appropriate responses and fill in the blanks.

MENTAL STATUS

Alert ☐
Oriented x3, person, place, time ☐
Confused ☐

Orientation fluctuates ☐
Wanders ☐
Unaware ☐

Memory Loss:

Short-term ☐ Long-term ☐

Semi-Comatose ☐ Comatose ☐

Comments

COGNITION

Understands information conveyed without difficulty ☐
Understands information conveyed but has difficulty ☐
Cannot understand information conveyed ☐
History of episodic confusion/disorganized thinking ☐
Frequently loses train of thought in conversation/inattention ☐

Attention deficit ☐
Short-term memory OK ☐
Long-term memory OK ☐

Altered level of consciousness:

Vigilant ☐ Lethargic ☐ Stuporous ☐

Comments:

EMOTIONAL

Sociable ☐ Friendly ☐ Quiet ☐
Anxious ☐ Noisy ☐

PAIN

Presence / Frequency:

None ☐ Less than daily ☐
Daily ☐ Constantly ☐

Intensity:

Mild ☐ Moderate ☐
Severe ☐

Location

Head ☐ Chest ☐
Back ☐ Abdomen ☐
Limbs: ☐ Specify
Feet ☐
Other

Relieved By:

Medication ☐ Position changes ☐
Heat ☐ Cold ☐
Massage ☐
Other
None of the above ☐
Comments

SKIN

Specify under comments for ALL items checked

Good ☐ Fair ☐
Dry ☐ Dry & fragile ☐
Bruises ☐ Skin tears ☐
Circulatory problems ☐ Abrasions ☐
Broken areas ☐ Excoriations ☐
Arterial ischemic ulcer ☐ Fistulas ☐
Venous stasis ulcer ☐ Diabetic ulcer ☐

Easily upset ☐ Hostile frequently ☐

Expresses according to situation ☐

Withdrawn ☐ Cooperative ☐

Depressed/down/hopeless ☐

Easily annoyed, short-tempered ☐

Comments:

SOCIAL

Supportive/Interactive family relationships ☐

Non-supportive/Non-interactive family relationships ☐

Frequent visitors ☐

Few visitors ☐

No visitors ☐

Comments:

BEHAVIOR PROBLEMS

Selg neglect ☐

Wanders/Gets lost ☐

Lacks awareness of own needs ☐

Violent/Assaultive/Physically abusive ☐

Resists hands-on-care/non-cooperative ☐

Verbally abusive ☐

Other

Comments:

Approaches used to control behavior:

Surgical ☐ Non-Surgical ☐

☐ Pressure Ulcers: Stage 1 ☐ Stage 2 ☐

Stage 3 ☐ Stage 4 ☐

Site/Location: (indicate on body form)

Date first observed __-__-____

Skin Treatments ☐

Specify

Comments

IDENTIFY SITE ON DIAGRAM BELOW

EDEMA

Yes ☐ No ☐

Degree: 1+ ☐ 2+ ☐ 3+ ☐

Location (Specify):

PSYCHOACTIVE MEDICATIONS

Psychoactive Medication Prescribed: ☐

Specify:

Target behaviors

Psychoactive Medication Reduced: ☐

Drug

Date changed __-__-____

Response to change

Psychoactive Medication Discontinued: ☐

Date __-__-____

Comments:

Side effects:

BLADDER

Continent ☐ Assist to bathroom ☐

Incontinent ☐

Specify number of times per day

Catheter ☐ Catheter size

Irrigation ☐

DX for catheter

External catheter ☐ Intermittent catheterization ☐

Urine color

Consistency

Amount

Treated for UTI in last 30 days ☐

Scheduled toileting program ☐

Prompted voiding program ☐

Bladder training program ☐

GROOMING

Self Care ☐ Shaves self ☐ Dresses self ☐

Staff shaves ☐ Needs assistance dressing ☐

Needs additional assistance: ☐

Specify

Total care: ☐

Comments

NAILS

Fingers:		**Toes:**	
Self Care	☐	Self Care	☐
Need frequent cutting	☐	Need frequent cutting	☐
Broken easily	☐	Broken easily	☐
Cut PRN by staff	☐	Cut PRN by staff	☐

Comments:

EATING HABITS

Appetite:

Good ☐ Usually good ☐ Usually poor ☐

Feeds self ☐ Feeds with assistance ☐ Fed ☐

Eats in dining room ☐ Eats in room ☐ Needs promts ☐

NG tube ☐ G-tube ☐ J-tube ☐ TPN ☐

Uses assistive device ☐

Specify

Diet order

(Supplemental feedings)

Percent of meals usually eaten

Breakfast Lunch

Dinner

Likes:

Comments:

Dislikes:

BOWEL

Regular ☐ Suppositories ☐ Enemas ☐

Incontinent ☐

Specify number of times per day

Ostomy ☐ Subject to constipation ☐

Diarrhea ☐ Loose stool ☐

Toileting program ☐

Laxatives ☐

How ordered

Comments:

ADULT DISPOSABLE BRIEFS

During sleep ☐ amount used daily:

While awake ☐ amount used daily:

Not used ☐ Chux used ☐ Sheet ☐

Wears pantyliners ☐ amount used daily:

Comments:

HYGIENE

Bathing:

How often

Bed bath ☐ Tub bath ☐

Shower ☐ Whirpul ☐

Shampoo weekly ☐

Goes to beathy shop ☐

Moisturizing lotion PRN ☐

Dentures ☐

Needs assistance ☐

Needs total staff care ☐

Comments:

SLEEP PATTERNS

Sleeps all night ☐ Restless ☐ Needs nap ☐

Needs rest ☐ Difficulty resting ☐

Awakens frequently ☐

Gets at least 5 hours uninterrupted sleep at night or during an 8-hour period:

Yes ☐ No ☐

Requires HS medication for sleep ☐

Comments:

VISION

Adequate ☐ Impaired ☐ Glasses ☐

Contacts ☐ Magnifying glass ☐

Can see newsprint ☐ Can see large print ☐

Cataracts ☐ Glaucoma ☐

Macular degeneration ☐ Blind ☐

Comments:

HEARING

Right Ear:		**Left Ear:**	
Adequate	☐	Adequate	☐
Impaired	☐	Impaired	☐
Hearing Aide	☐	Hearing Aide	☐
Deaf	☐	Deaf	☐

Minimal difficulty when not in quiet listening conditions ☐

Have to adjust tonal quality & speak distinctly ☐

Highly impaired, lack of useful hearing ☐

Has own teeth ☐
Edentulous ☐
Caries ☐

Bridge: Removable / Permanent ☐
Implants ☐

Condition of mouth ☐
(specify)

Self-Care ☐
(specify)

Comments:

SPEECH

Clear ☐ Difficulty ☐ Slurred ☐
Aphasia ☐ Unclear ☐

Normal ☐ Low tone ☐ Mute ☐
Trach ☐ Uses voicebox ☐

Communicates & is understood ☐
Communicates but is difficult to understand ☐
Cannot communicate or convey needs ☐
Comments:

AMBULATION

Ambulates:

Alone ☐ With assistance ☐
Most of day ☐ Short periods ☐
Pushes wheelchair for support ☐
Bed to chair ☐ With cane or crutch ☐
With walker ☐

Wheelchair:

Propels self ☐ Short distances ☐
Long distances ☐
Propels with staff assistance ☐
Unable to propel ☐

Comments:

FALLS

Recent fall ☐ Date __-__-____
Injury: ☐
Specify

Comments:

SAFETY DEVICES

Not used ☐ **OR** Not Applicable ☐
Enablers ☐
Specify

Side rails ☐ Safety belt ☐ Vest ☐
Lap buddy ☐ Geri-chair ☐
Other ☐
Specify

When used?

Medical Dx/Reason

Where used?

Use: Reduced ☐ Eliminated ☐ Yes ☐
If Yes, result No ☐

Amputation ☐ Paralysis ☐

Comments:

TRANSFERS

Independently ☐ Assist. of 1 ☐

Assist. of 2 ☐ Gaitbelt used ☐

Mechanical lift ☐

Comments

POSITIONING

Self ☐

Every 2 hours: While in bed ☐ Chair ☐

Transfer: 1-Person ☐ 2-Person ☐

Transfer aide (specify)

Other (specify)

Comments:

CONTRACTURES

None ☐

Hand: ☐ Left ☐ Right ☐ Arm: ☐ Left ☐ Right ☐

Leg: ☐ Left ☐ Right ☐ Foot: ☐ Left ☐ Right ☐

Device(s) used:

Comments:

If No, reason

Comments:

REHAB

Physical therapy ☐ Occuoations therapy ☐

Speech therapy ☐ Respiratory therapy ☐

Restorative nursing ☐

Adaptive devices ☐ (Specify)

Splints ☐ (Specify)

Braces ☐ (Specify)

Comments:

VITALS

Temp Pulse

Respirations B/P

Current weight IBW

Weight 30 days ago

Weight 6 months ago

Allergies (specify)

Comments:

ADDITIONAL COMMENTS

Residents at High Risk of Entering the Actively Dying Process

The following characteristics should prompt proactive advance care planning, and consideration of a Palliative Care plan, Comfort Care Orders, and/or enrollment in Hospice:

- ☐ Frequent Emergency Room visits and/or hospitalizations over the last 6 months
- ☐ Semi-comatose state
- ☐ Minimal oral intake (or receiving continuous IV hydration or tube feeding)
- ☐ Inability or difficulty with taking oral medicines
- ☐ Major decline in functional status with no identified reversible cause
- ☐ Mottling of extremities
- ☐ Primary diagnosis of metastatic cancer
- ☐ Primary diagnosis of advanced dementia
- ☐ Existing DNR order

SBAR

Physician/NP/PA Communication and Progress Note

Before Calling MD/NP/PA:

- ☐ **Evaluate the resident,** complete the SBAR form
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ **Review chart** (most recent progress notes and nurse's notes from previous shift, any recent labs)
- ☐ **Review an INTERACT II Care Path or Acute Change in Status File Card** if indicated
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

This is _____ I am calling about _____

The problem/symptom I am calling about is _____

The problem/symptom started _____

The problem/symptom has gotten _____ since it started

Things that make the problem/symptom worse are _____

Things that make the problem/symptom better are _____

Other things that have occurred with this problem/symptom are _____

BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home _____

Pertinent medical history/include recent falls, fever, decreased intake/fluids, CP, SOB, other

_____

Mental Status or Neuro changes: (Y/N: confusion/agitation/lethargy) _____

Temp _____ BP _____ Pulse rate/rhythm _____ Resp rate _____

Lung Sounds _____

Pulse Oximetry _____ % On RA _____ on O2 at _____ L/min via _____ (NC, mask)

GI/GU changes (nausea/vomiting/diarrhea/impaction/distension/decreased urinary output) _____

Pain level/location/status _____

Change in function/intake/hydration _____

Change in Skin Color _____ Wound Status (if applicable) _____

Labs _____

Medication changes or new orders in the last two weeks _____

Advance Directives (Full code, DNR, DNI, DNH, other, not documented) _____

Allergies _____ Any other data _____

ASSESSMENT (RN) or APPEARANCE (LPN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?)

I think that the problem may be _____

I am not sure of what the problem is, but there had been an acute change in condition. ☐

(For LPNs): The patient appears ? _____ (e.g. SOB, in pain, more confused)

REQUEST

I suggest or request:

- ☐ Provider visit (MD/NP/PA)
- ☐ Monitor vital signs (Frequency _____) and observe
- ☐ Lab work, xrays, EKG, other tests _____
- ☐ Medication changes _____
- ☐ New orders _____
- ☐ IV or SC fluids _____

Staff name _____

Reported to: _____ **Date** __-__-____ **Time** ::

If to MD/NP/PA, communicated by: ☐ **Phone** ☐ **Fax (attach confirmation)** ☐ **In person**

Patient name _____

Progress Note

Skilled Daily Nurses Note

Resident Name Assessment Date

DIRECTIONS: Check all applicable boxes per shift. Signature of nurse for appropriate shift. If 12 hour shift, do not code in "E" boxes.

Vital Signs

	D:	E:	N:
T			
P			
R			
B/P			
Abnormal	☐	☐	☐

Hearing/Speech/Vision

	D	E	N
WNL	☐	☐	☐
Comatose	☐	☐	☐
Unable to Hear	☐	☐	☐
Hearing Aid: Rt/Lt	☐	☐	☐
Unable to Speak	☐	☐	☐
Unclear Speech	☐	☐	☐
Unable to Make Self Understood	☐	☐	☐
Unable to See	☐	☐	☐
Corrective Lenses: Y / N			

Comments

Mood

	D	E	N
Little Interest/Pleasure in Doing Things	☐	☐	☐
Depressed/Hopeless	☐	☐	☐
Abnormal Sleep Patterns	☐	☐	☐
Tired/Little Energy	☐	☐	☐
Poor Appetite/Overeating	☐	☐	☐
Feeling Bad About Yourself	☐	☐	☐
Inability to Concentrate	☐	☐	☐
Restless/Fidgety/Anxious	☐	☐	☐

Cognitive Patterns

	D	E	N
Alert	☐	☐	☐
Disoriented:	☐	☐	☐
Person	☐	☐	☐
Place	☐	☐	☐
Time	☐	☐	☐
Long-term Memory Dx. Unable to Recall Long Past	☐	☐	☐
Short-term Memory Dx. Unable to Recall Last 5 Minutes	☐	☐	☐
Inattention	☐	☐	☐
Disorganized Thinking	☐	☐	☐
Vigilant	☐	☐	☐
Lethargic	☐	☐	☐
Stuporous	☐	☐	☐
Psychomotor Retardation	☐	☐	☐

Comments

Behavior

	D	E	N
Hallucinations	☐	☐	☐
Illusions	☐	☐	☐
Delusions	☐	☐	☐
Inappropriate Physical Behaviors (hitting, scratching)	☐	☐	☐

Self-deprivation/Suicidal Thoughts	☐	☐	☐
Short-tempered/Annoyed	☐	☐	☐

Comments

Inappropriate Verbal Behaviors (screaming, cursing)	☐	☐	☐
Inappropriate Sexual Behaviors	☐	☐	☐
Inappropriate Social Behaviors (throwing food)	☐	☐	☐
Wandering	☐	☐	☐
Rejects Care	☐	☐	☐
Risk for Physical Injury	☐	☐	☐
Disrupts Care/Living Environment	☐	☐	☐

Comments

Functional Status	D	E	N

CODE 1: SELF-PERFORMANCE Activity 3 or More Times
0. Independent
1. Supervision
2. Limited Assistance
3. Extensive Assistance
4. Total Dependence

Activity 2 or Less Times
7. Activity Occurred 1 or 2 Times
8. Activity Did Not Occur Entire Shift

Bed Mobility			
Transfer			
Walk In Room			
Walk In Corridor			
Locomotion On Unit			
Locomotion Off Unit			
Dressing			
Toilet Use			
Personal Hygiene			
Eating			
Bathing			

CODE 2: SUPPORT PROVIDED
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur

Bed Mobility			
Transfer			
Walk In Room			
Walk In Corridor			
Locomotion On Unit			
Locomotion Off Unit			

Bowel & Bladder	D	E	N
WNL		☐	
Catheter Type:			
Scheduled Toileting		☐	
Bladder Training	☐	☐	☐
Prompted Voiding	☐	☐	☐
Burning	☐	☐	☐
Distention/Retention	☐	☐	☐
Frequency/Urgency	☐	☐	☐
Hematuria	☐	☐	☐
Discharge	☐	☐	☐
Bladder Incontinence	☐	☐	☐
Urine:			
Color:			
Consistency:			
Odor:			
Dialysis	☐	☐	☐
Briefs/Pads Utilized	☐	☐	☐

Dressing			
Toilet Use			
Personal Hygiene			
Eating			
Bathing			

Comments:

GI	D	E	N
Anorexia	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Epigastric Distress	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Difficulty Chewing	☐	☐	☐
Abdominal Distension	☐	☐	☐

Comments

Pain	D	E	N
No c/o's of Pain	☐	☐	☐
Origin:			
Location:			
Intensity (0-10):			

Comments:

Respiratory			
Normal	☐	☐	☐
Labored Breathing	☐	☐	☐
Shallow Respirations	☐	☐	☐
Rales/Rhonchi	☐	☐	☐

Bowel Incontinence	☐	☐	☐
Ostomy, Type:			
Diarrhea	☐	☐	☐
Constipation/Impaction	☐	☐	☐
Bowel Sounds:			
Present	☐	☐	☐
Absent	☐	☐	☐
Hyperactive	☐	☐	☐
Hypoactive	☐	☐	☐

Comments:

Cardiovascular	D	E	N
Regular Rhythm/WNL	☐	☐	☐
Radial/Apical Irregular	☐	☐	☐
Capillary Refill Sluggish	☐	☐	☐
Neck Vein Distention	☐	☐	☐
Chest Pain	☐	☐	☐
Edema:			
Dependent	☐	☐	☐
Pitting: +1	☐	☐	☐
+2	☐	☐	☐
+3	☐	☐	☐
+4	☐	☐	☐
Abnormal Peripheral Pulses	☐	☐	☐
Change in Vital Signs	☐	☐	☐
Abnormal Heart Sounds/ Murmur	☐	☐	☐
Dizziness When Standing	☐	☐	☐
Increased Fatique	☐	☐	☐
Increased Weight	☐	☐	☐

Wheezing	☐	☐	☐
Cough	☐	☐	☐
Orthopnea	☐	☐	☐
Dyspnea/SOB	☐	☐	☐
O2 ____ LPM			
☐ PRN	☐	☐	☐
☐ Continuous	☐	☐	☐
SaO2 ____ %/%/%	☐	☐	☐
Nebulizer Tx	☐	☐	☐
Suctioning	☐	☐	☐
Tracheostomy/Care	☐	☐	☐
Ventilator/Respirator	☐	☐	☐
BiPAP/CPAP	☐	☐	☐

Comments:

Musculoskeletal

Steady Gait	☐	☐	☐
Problem With Balance	☐	☐	☐
Paralysis/Weakness	☐	☐	☐
Gait Unsteady	☐	☐	☐

Comments:

Skin

Skin Color Normal	☐	☐	☐
Jaundiced	☐	☐	☐
Cyanosis	☐	☐	☐
Pallor	☐	☐	☐
Clammy	☐	☐	☐
Chills	☐	☐	☐

Comments

Neuro/Muscular System

	D	E	N
Syncope	☐	☐	☐
Headache	☐	☐	☐
Abnormal Pupil Reaction			
Right	☐	☐	☐
Left	☐	☐	☐
Tremors	☐	☐	☐
Vertigo	☐	☐	☐
Decreased Grasp			
Rt	☐	☐	☐
Lt	☐	☐	☐
Decreased Movement			
☐ RUE LUE ☐	☐	☐	☐
☐ RLE LLE ☐	☐	☐	☐

Comments

Skin (Cont'd.)

Flushing of Skin	☐	☐	☐
Rash/Itching	☐	☐	☐
Abnormal Turgor/Elasticity	☐	☐	☐
Desensitized to Pain/Pressure	☐	☐	☐
Bruises	☐	☐	☐
Diabetic Ulcer(s)	☐	☐	☐
Pressure Ulcer(s)	☐	☐	☐
Deep Tissue Injury	☐	☐	☐
Unstageable Ulcer	☐	☐	☐
Surgical Wound(s)	☐	☐	☐
Burns	☐	☐	☐
Skin Tear/Laceration(s)	☐	☐	☐

Skin (Cont'd.)

Comments

Signature(s)

D:

E:

N:

SERVICES PROVIDED

Skilled Observation & Assessment	☐	Wound Care/Dressings	☐
Management & Eval of Resident Care Plan	☐	Pressure Ulcer Management	☐
Dehydration/Fluid Intake	☐	Stasis Ulcers	☐
Chemotherapy Management/Teach	☐	Central/Peripheral IV Therapy	☐
Dialysis Management	☐	Tracheostomy Care/Suctioning	☐
Observe for/Teach Medication Effects/Side Effects	☐	IV Medication	☐
Observe S/Sx infection	☐	Intramuscular Injections	☐
Teach Diabetic Care (Insulin, Diet, Foot-care, etc.)	☐	Tube Feeding (must meet requirements)/IV Feeding	☐
Gait Training/Prosthesis Care	☐	Pain Management	☐
Self-administration of Injectable Meds	☐	Therapy (PT, OT, ST, RT)	☐
Teach & Ostomy/Ileo Conduit Care	☐	Nursing Rehabilitation	☐
Hospice	☐	Chest Physio/Postural Drainage	☐
Diet Teaching	☐	Ventilator/Respirator	☐
Bowel & Bladder Training	☐	Teach Inhalation Rx	☐
Teach/Care IV Catheter Sites	☐	Braces, Casts, Splints, Orthotics, etc. Care/Teach	☐

Other

Comments

SOCIAL WORK THERAPY NOTE

Resident Room Assessment Date

Current Psychiatric Symptoms and Manifestations:

Appearance:

☐ Neat ☐ Slightly Disheveled ☐ Disheveled ☐ Bizarre ☐ Unkempt/Poor Grooming

Orientation:

☐ Alert ☐ Person ☐ Place ☐ Time ☐ Self only ☐ Severe Impairment

Cognition:

☐ STM deficit ☐ LTM deficit ☐ impaired reality testing ☐ impaired decision making

Eye Contact:

☐ Appropriate ☐ Minimal ☐ Excessive/Provocative ☐ None

Perception:

☐ Altered perception ☐ Disorganized thinking ☐ Loose associations ☐ Delusions

☐ Hallucinations ☐ Paranoia ☐ Grandiose ☐ Obsessions

Thought Processes/Content:

☐ Loose associations ☐ Racing Thoughts ☐ Tangential ☐ Paranoia ☐ Grandiose

☐ Delusions ☐ Hallucinations ☐ Preoccupations ☐ Obsessions ☐ Phobias

Other:

Suicidal Ideation:

☐ Denies/Absent ☐ Ideation ☐ Threats ☐ Plan ☐ Means ☐ Intent

Other:

Homicidal Ideation:

☐ Denies/Absent ☐ Ideation ☐ Threats ☐ Plan ☐ Means ☐ Intent

Other:

Mood:

☐ Neutral ☐ Anxious ☐ Sad/Depressed ☐ Manic ☐ Irritable ☐ Angry ☐ Apathetic

Other:

Behavior:

☐ Appropriate ☐ Threatening/Intimidating ☐ Physically Aggressive ☐ Sexual Aggression

☐ Withdrawn/Isolative ☐ Verbally aggressive ☐ Manipulative ☐ Socially Inappropriate

☐ Bizarre Behavior ☐ Refuses meds ☐ ETOH ☐ Drugs ☐ Psychomotor Behavior

Other:

Psychosocial Functioning:

☐ Involved in treatment ☐ Involved in milieu ☐ Relationship formation ☐ Inapprop. Relations

Judgment/Insight:

☐ Normal Judgment ☐ Impaired Judgment ☐ Normal Insight ☐ Limited Insight ☐ No Insight

Other:

Problem:

☐ Signs/symptoms of depression ☐ Signs/symptoms of anxiety ☐ Impaired social skills

☐ Limited social interaction ☐ Impaired judgment and decision making ☐ Resists care

☐ Poor impulse control ☐ Difficulty adjusting to NH

Other: _____

Themes Discussed:

☐ History: Emotional ☐ History: Physical ☐ History: Sexual ☐ ETOH ☐ Drugs

☐ Anger mgt ☐ Appetite problems ☐ Assertiveness ☐ Behavior ☐ Community living

☐ Conflict mgt skills ☐ Declining function ☐ Discharge ☐ Divorce ☐ Dying/death

☐ Facility ☐ Adjustment to NH ☐ Family ☐ Financial Problems ☐ Grief

☐ Healthy Eating ☐ Coping w/ loss of independence ☐ Reminiscence ☐ Self-Esteem ☐ Sex

☐ Depression/Anxiety ☐ Grooming/Hygiene ☐ Leisure time mgt ☐ Marriage ☐ Memory

☐ Healthy decision making ☐ Problem solving ☐ Interpersonal relationships ☐ Medication

☐ Parent/child ☐ Participation/Activities ☐ Peers ☐ Physical symptoms ☐ Safety awareness

☐ Self-mgt skills ☐ Sleep disorder ☐ Social Skills ☐ Symptom mgt ☐ Life mgt skills

☐ Coping with pain ☐ Physical activity ☐ Friendship ☐ Intimate relationships ☐ Conflict mgt

Clinical Observation:

Participation:

☐ Participates actively ☐ Asks questions ☐ Role plays ☐ Answers questions ☐ Pays attention

☐ Shows interest in discussion ☐ Willing/motivated in session ☐ Little motivation in session

Therapist Interventions:

☐ Utilize structured exercise ☐ Role play ☐ Provide encouragement ☐ Supportive counseling

☐ Praise for efforts ☐ Model desired techniques ☐ Provide information/education

☐ Provide reminders ☐ Escort to session

Other: _____

Response to Treatment:

☐ Accepts approaches ☐ Understands/accepts problem ☐ Exhibits goal related responses

☐ Shows progress toward objectives ☐ Shows little progress toward objectives

☐ Shows no progress toward objectives ☐ Requires repeated prompts/reinforcement

Other: _____

Length of Session:

☐ Half Session: 20-30 minutes ☐ Full Session: 45-60 minutes Other _____

_____ _____ __-__-____

Evaluator Attending Physician Date

SUICIDE RISK ASSESSMENT WORKSHEET

Resident Name: Room: Assessment Date:

Gender: Date of Birth: Age: Ethnicity:

Attending Physycian:

Historical Risk Factors

Axis I History

- Substance Abuse Disorders
- Mood Disorders
- Anxiety Disorders
- Psychotic Disordes

Axis II History

- Borderline PD
- Narcissistic PD
- Antisocial PD

Axis III History

- Chronic Pain
- Chronic Illness
- Recent Illness

Axis IV History

- Legal Problems
- Vocational Stressor
- Primary Relationship Stressor
- Recent Homelessness
- Financial Stressor

Suicide History

- History of threats
- History of attempts
  - Severity of attempts:
- History of non-suicidal self-harm

Current Risk Factors

Demographic Risk Factors

- ☐ Male
- ☐ Lives Alone

☐ Widowed/Separated

☐ Native American

Self Reported Risk Factors

Ideation

Passive/Active | Duration | Frequency

Plan

Intent

Means

Suicide Rehearsal

Suicide Preparation

Hopelessness

Psychological Pain (s/s of depression)

Active Substance Abuse

Impulsivity

Self-assessment re: risk

Has Command Hallucinations

Wants revenge

Has a terminal illness

Suicidal Plan

Level of lethality

Suicidal Intent

Suicidal Means

What has stopped resident in past?

Current Deterrents to suicide, self-reported

Religious Faith

Faith/hopefulness re: solutions/resolution

Reality testing ability

Ambivalence

Reasons for living

Loved ones

Positive social support

Relationship with therapist

Other

Mental Status Observations

Appearance

Attitude

Orientation

Memory

Intellectual abilities

Reality Orientation

Attention Span

Behavior

(psychomotor behaviors, interacts appropriately, appropriately structures time, frequently inappropriate, withdrawn pacing, acting out behavior, bizarre behavior, substance abuse, unhealthy/dangerous behaviors, wanders, curses, yells, threatens/intimidates, resists care (medications), resists care (treatment), resists care (ADLs), resists care (eating), is manipulative, is attention seeking, has unsafe smoking behavior, is disruptive, pushes/strikes out at others, spits at others, spits on walls/floors, runs into ppl wheelchair, throws things, is demanding, is self-abusive, rummages, smears feces, destroys property,
hoards items, is promiscuous, fails to use privacy curtains, masterbates in public areas, touches others w/o permission, wears bizarre clothing, kicks others, pulls hair)

Thought Processes/Content (form/content)

Communication/Speech

Affect

Mood

Perception (vision/hearing)

Insight

Judgment

Motivation

Double click or pressing Enter in the box will give you a list of options to select from

Diagnostic Impression

Axis I

Axis II

Axis III

Axis IV

Axis V

Risk Potential Categories

(Determination of Risk Level: Clinical judgment based upon consideration of relevant risk factors, present episode of illness, symptoms, and specific suicide inquiry)

- **Low Risk:** Denies current violent suicidal or homicidal ideation; no indicators evident
    - *Low Risk Interventions:*
        - Monitor for any changes that may increase risk
- **Moderate Risk:** Violent ideation without intent
    - *Moderate Risk Interventions:*
        - Repeated evaluation of the need for hospitalization
        - Facilitate communication with psychiatrist to report symptoms
        - Recommend psychotropic medication evaluation/adjustment
        - Initiate/Recommend psychotherapeutic intervention
        - Active involvement of family members, if possible
        - Frequent reevaluation of suicide risk, evaluating specific changes that increase or decrease risk
- **High Risk:** Strong ideation with intent
    - *High Risk Interventions:*
        - Communicate the immediate danger of acting on suicidal thoughts/ Initiate prompt clinical attention/psychiatric hospitalization.
        - Provide adequate resident safety.
            - Confine resident to safe area/Remove dangerous objects
            - Monitor resident 1:1
            - Use appropriate chemical restraints
        - Stabilize current medical conditions
- **Additional Interventions:**
    - *o* Refer for psychotherapy
    - *o* Refer for individual psychosocial counseling
    - *o* Refer for psychosocial group counseling

Take special precaution when dealing with residents who are intoxicated or in withdrawal. They are potentially violent due to cognitive deficits, disinhibition, and profound agitation.

TINETTI ASSESSMENT TOOL: BALANCE AND GAIT

Patient Name: ID#:

Date: __-__-____ Assessor: (signature/title)

Initial Instructions: Subject is seated in a hard, armless chair. The following maneuvers are tested.

Task	Description of Balance	Possible	Score
1. Sitting balance	Leans or slides in chair Steady, safe	= 0 = 1	
2. Arises	Unable without help Able, uses arms to help Able without using arms	= 0 = 1 = 2	
3. Attempts to arise	Unable without help Able, requires greater than 1 attempt Able to rise, 1 attempt	= 0 = 1 = 2	
4. Immediate standing balance (first 5 seconds)	Unsteady (swaggers, moves feet, trunk sway) Steady but uses walker or other support Steady without walker or other support	= 0 = 1 = 2	
5. Standing Balance	Unsteady Steady but wide stance (medial heels greater than 4 inches apart) and uses cane or other support Narrow stance without suppor	= 0 = 1 = 2	
6. Nudged (subject at max position with feet as close together as possible, examiner pushes lightly on subject's sternum with palm of hand 3 times	Begins to fall Staggers, grabs, catches self Steady	= 0 = 1 = 2	
7. Eyes closed (at maximum position #6)	Unsteady Steady	= 0 = 1	
8. Turning 360 degrees	Discontinuous steps Continuous steps Unsteady (grabs, swaggers) Steady	= 0 = 1 = 0 = 1	
9. Sitting down	Unsafe (misjudjed distance, falls into chair) Uses arms or not a smooth motion Safe, smooth motion	= 0 = 1 = 2	
		Balance Score:	

Initial Instructions: Subject stands with examiner, walks down hallway or across the room, first at "usual" pace, then back at "rapid, but safe" pace (using usual walking aids).

Task	Description of Balance	Possible	Score
10. Initiation of gait (immediately after told to "go")	Any hesitancy or multiple attemps to start No hesitancy	= 0 = 1	
11. Step length and height	a. Right swing foot does not pass left stance foot with step b. Right foot passes left stance foot c. Right foot does not clear floor completely with step d. Right foot completely clears floor e. Left swing foot does not pass right stance foot with step f. Left foot passes right stance foot g. Left foot does not clear floor completely with step h. Left foot completely clears floor	= 0 = 1 = 0 = 1 = 0 = 1 = 0 = 1	

Task	Description of Balance	Possible	Score
12. Step symmetry	Right and left step length not equal (estimate) Right and left step appear equal	= 0 = 1	
13. Step continually	Stopping or discontinuity between steps Steps appear continuous	= 0 = 1	
14. Path (estimated in relation to floor tiles, 12-inch diameter; observe excursion of 1 foot over about 10 feet of the course)	Marked deviation Mild/moderate deviation or uses walking aid Straight without walking aid	= 0 = 1 = 2	
15. Trunk	Marked sway or uses walking aid No sway but flexion of knees or back, or spreads arms out while walking No sway, no flexion, no use of arms, and no use of walking aid	= 0 = 1 = 2	
16. Walking stance	Heels apart Heels almost touching while walking	= 0 = 1	
Key for Scoring: Maximum score is 28 Score below 19 “High risk of falling” Score in 19-24 range “Greater chance of falling” but is not at “High risk” Score in 24-28 range “Low risk of falling”		**Gait Score:**	
		Balance + Gait Score:	

UNPLANNED TRANSFER ASSESSMENT

DEMOGRAPHIC INFORMATION

Name Age

Room # Unit

Resident ID

Date of Last Admission to the Nursing Facility __-__-____

Financial Class

TRANSFER DETAILS

Nurse (RN/LPN) involved in transfer

Supervisor on Duty (RN/LPN)

Date of Transfer __-__-____ Time of Transfer ::

Was patient sent by EMS (911)? ☐

What was not available in order to assess or treat the individual in the facility? (Check and specify)

- ☐ Diagnostic services
- ☐ Equipment
- ☐ Staff
- ☐ Other

EFFORTS TO HANDLE SITUATION WITHOUT TRANSFER

What was done to try to assess and treat in the facility? (Check)

- ☐ Physician on-site evaluation / Nurse practitioner on-site evaluation
- ☐ Practitioner in-depth telephone discussion
- ☐ Intravenous or subcutaneous fluids
- ☐ Lab tests
- ☐ X-rays
- ☐ Other tests
- ☐ EKG, rhythm strip
- ☐ Administer medications
- ☐ Other

FACTORS LEADING TO TRANSFER DECISION

Reason(s) for Hospital Transfer (check all that apply)

- ☐ **Medical instability** (e.g., unstable vital signs, seizures, change in mental status, etc.)

Please specify:

- ☐ **Physician** (e.g., MD insisted, MD unavailable)
- ☐ **Ethical Issues** (e.g., no or incomplete advance directive)
- ☐ **Family issues** (e.g., family insisted, family in conflict)
- ☐ **Other**

Who authorized the transfer?

Other

Was the individual admitted to the hospital? ☐

Reason (s) for Transfer (check all that apply)

- ☐ Fever
- ☐ Altered mental status
- ☐ Dehydration/decreased po intake
- ☐ Pneumonia or lower respiratory infection
- ☐ UTI
- ☐ Heart Failure
- ☐ COPD
- ☐ Injury
- ☐ GI – nausea, vomiting, diarrhea
- ☐ Skin infection (e.g., cellulites, infected pressure ulcer)
- ☐ Psychiatric (e.g., agitation, psychosis, suicidal ideation)
- ☐ Suspected DVT
- ☐ Other (describe)

DETERMINATION OF AVOIDABILITY

Based on review, hospital transfer was:

Signature of Person Completing Form

Date of completion __-__-____

Weight Loss Nutrition Assessment

Name **Room#** **Medical Record #**

Physician **Assessment Date** **Sex**

Significant Change (#) % days **Weight loss trend**

Weights are currently obtained

Advance directive **Capacity** **Incapacity** **Safe Harbor Level**

Diagnosis

Current Diet / TF Order

Supplements / Snacks

Swallowing ability **Chewing Ability**

Able to feed self Comments

Dentition: Natural Dentition Condition

Dentures: Fit Worn Comments

GI Symptoms: Nausea Vomiting Diarrhea Constipation

Pertinent Medications

Labs / Date: __-__-____ **Albumin** **Pre-Albumin** **BUN**

Creat **K+** **Hgb** **Hct**

Other

Skin Status: Intact Pressure Ulcer / Non-healing wound

Edema: Location

List any current changes:

Interventions / Recommendations

- ☐ House Supplement
- ☐ Liberalize Diet
- ☐ Add Extra Portions
- ☐ Add Snacks between meals
- ☐ Vitamin/mineral supplements
- ☐ Update food preferences
- ☐ Finger Food Diet
- ☐ Weekly Weights until stabilized
- ☐ Dental Cosult
- ☐ Refer to Pharmacist for medicaton review
- ☐ Refer to other Departments:
- ☐ Request labs:

Other:

Signature _____ Date __-__-____

RD Signature _____ Date __-__-____

Physician Signature _____ Date __-__-____

Weight Loss Review

Resident **Room/Bed** **Medical Record #**

☐ **Resident's weight has stabilized since last review.**

☐ **Resident has gained weight since last review. Explain:**

☐ **Resident has experiences weight loss since last review. Explain:**

Other:

Plan:

Reviewed by **Date** __-__-____

☐ **Resident's weight has stabilized since last review.**

☐ **Resident has gained weight since last review. Explain:**

☐ **Resident has experiences weight loss since last review. Explain:**

Other:

Plan:

Reviewed by **Date** __-__-____

☐ **Resident's weight has stabilized since last review.**

☐ **Resident has gained weight since last review. Explain:**

☐ **Resident has experiences weight loss since last review. Explain:**

Other:

Plan:

Reviewed by **Date** __-__-____

Wound Photo Documentation

Resident Name: Date:

LOCATION (ANATOMICAL SITE):

WOUND TYPE:

Wound Location

Pressure Ulcer ☐

Stage

Arterial ☐ Venous ☐

Diabetic ☐ Surgical ☐

Other ☐ (Specify)

Size (cm) (LxW):

Depth (cm):

Tunneling (cm) (LxW)

Undermining (cm):

Date first observed: __-__-____

Granulation %:

EXUDATE:

Odor: None ☐ Slight ☐ Moderate ☐ Foul ☐

Type: None ☐ Bloody ☐ Serosanguineous ☐ Purulent / Foul ☐

Amt: None ☐ Scant ☐ Small ☐ Moderate ☐ Large ☐ Copious ☐

WOUND BED:

Normal for skin ☐ Slough ☐

Pink/beefy red tissue ☐ Black/brown (eschar) ☐

Granulation tissue ☐

SURROUNDING SKIN COLOR:

Normal for skin ☐ White/gray pallor ☐

Pink ☐ Dark red/purple ☐

Bright red ☐ Black/brown ☐

WOUND EDGES/SURROUNDING TISSUE:

Normal for skin ☐

Peripheral tissue edema ☐

Hardness/induration ☐

Rolled edges ☐

Maceration ☐

Nurse's Signature: