INITIAL ASSESSMENT/ EVALUATION

Name: _____ Date: _____

Current Address: _____ Room:_____

Address: _____ Phone:_____

Facility Assessment

General Impressions of the Facility: (Are residents yelling, is there a smell, are most residents just dozing in wheelchairs?)_____

_____

Room Appearance: _____

_____

Client Assessment

Sex:_____ Age:_____ SSN#_____

General Appearance: _____

_____

_____

Client Location (at time of visit):_____

_____

Cognitive Status: _____

Continence Status: _____

Ambulatory Status: _____

Behavioral Issues: _____

Social Interactions: _____

Medical Chart Summary (include dates)

Diagnosis: _____

Prognosis: _____

Medications/ Dosage: _____

Date of Last Physician's Visit: _____

Physician's Name: _____

Physician's Orders: _____

_____

Physical Therapy: _____

Current Advance Directives: _____

Dietary habits: _____

Percentage of Meals Eaten: _____

Current Weight:_____ Weight Trend: _____

Medical Chart Summary: _____

_____

Rehabilitation Potential: _____

_____

_____

<u>Summarizations</u>

Immediate Needs/ Concerns: _____

_____

_____

_____

Summary of Evaluation: _____

_____

_____

_____

Facility Recommendations: _____

_____

_____

_____

Suggestions/ Comments: _____

_____

_____

_____

_____

_____

Assessment made by: _____