

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: _____

Summarizations

Immediate Needs/ Concerns: _____

Summary of Evaluation: _____

Facility Recommendations: _____

Suggestions/ Comments: _____

Assessment made by: _____