

Resident Name _____

Date of Birth _____

Date Completed _____

5. History. Does the resident have a history or current problem related to abuse of prescription, non-prescription, over-the-counter (OTC), illegal drugs, alcohol, inhalants, etc?

(a) Substance: OTC, non-prescription medication abuse or misuse

1. Recent (within the last 6 months) Yes No
 2. History Yes No

(b) Abuse or misuse of prescription medication or herbal supplements

1. Currently Yes No
 2. Recent (within the last 6 months) Yes No

(c) History of non-compliance with prescribed medication

1. Currently Yes No
 2. Recent (within the last 6 months) Yes No

(d) Describe misuse or abuse: _____

- 6.* Risk factors for falls and injury. Identify any conditions about this resident that increase his/her risk of falling or injury (check all that apply):

orthostatic hypotension osteoporosis gait problem impaired balance confusion Parkinsonism foot deformity
 pain assistive devices other (explain) _____

- 7.* Skin condition(s). Identify any history of or current ulcers, rashes, or skin tears with any standing treatment orders. Also note in Item 12(c) easy bruising, etc., and causes: _____

- 8.* Sensory impairments affecting functioning. (Check all that apply.)

(a) Hearing: Left ear: Adequate Poor Deaf Uses corrective aid
 Right ear: Adequate Poor Deaf Uses corrective aid

(b) Vision: Adequate Poor Uses corrective lenses Blind (check all that apply) – R L

(c) Temperature Sensitivity: Normal Decreased sensation to: Heat Cold

9. Current Nutritional Status. Height _____ inches Weight _____ lbs.

(a) Any weight change (gain or loss) in the past 6 months? Yes No

(b) How much weight change? _____ lbs. in the past ____ months (check one) Gain Loss

(c) Monitoring necessary? (Check one.) Yes No

If items (a), (b), or (c) are checked, explain how and at what frequency monitoring is to occur: _____

(d) Is there evidence of malnutrition or risk for undernutrition? Yes No

(e)* Is there evidence of dehydration or a risk for dehydration*? Yes No

(f) Monitoring of nutrition or hydration status necessary? Yes No

If items (d) or (e) are checked, explain how and at what frequency monitoring is to occur: _____

(g) Does the resident have medical or dental conditions affecting: (check all that apply)

Chewing Swallowing Eating Pocketing food Gastronomy tube fed

(h) Note any special therapeutic diet (e.g., sodium restricted, renal, calorie, or no concentrated sweets restricted): _____

(i) Modified consistency (e.g., pureed, mechanical soft, or thickened liquids): _____

(j) Is there a need for assistive devices with eating (check all that apply): Yes No

Weighted spoon or built up fork Plate guard Special cup/glass

(k) Monitoring necessary? (Check one.) Yes No

If items (g), (h), or (i) are checked, please explain how and at what frequency monitoring is to occur: _____

Resident Name _____
 Date of Birth _____

Date Completed _____

10.* Cognitive/Behavioral Status.

- (a)* Is there evidence of dementia? (Check one.) Yes No
- (b) Has the resident undergone an evaluation for dementia? Yes No
- (c)* Diagnosis (cause(s) of dementia): Alzheimer's Disease Multi-infarct/Vascular Parkinson's Disease Other
- (d) Mini-Mental Status Exam (if tested) Date _____ Score _____

10(e)* Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details.

Item 10(e)	A	B*	C*	D*	Comments
Cognition					
I. Disorientation	Never	Mild	Moderate	Severe	
II. Impaired recall (recent/distant events)	Never	Occasional	Regular	Continuous	
III. Impaired judgment	None	Mild	Moderate	Severe	
IV. Hallucinations	Never	Occasional	Regular	Continuous	
V. Delusions	Never	Occasional	Regular	Continuous	
Communication					
VI. Receptive/expressive aphasia	None	Mild	Moderate	Severe	
Mood and Emotions					
VII. Anxiety	Never	Occasional	Regular	Continuous	
VIII. Depression	None	Mild	Moderate	Severe	
Behaviors					
IX. Unsafe behaviors	Never	Occasional	Regular	Continuous	
X. Dangerous to self or others	Never	Occasional	Regular	Continuous	
XI. Agitation (Describe behaviors in comments section)	Never	Occasional	Regular	Continuous	

10(f) Health care decision making capacity. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, indicate this resident's highest level of ability to make health care decisions.

- (a) Probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens and risks of proposed treatment).
- (b) Probably can make limited decisions that require simple understanding.
- (c) Probably can express agreement with decisions proposed by someone else.
- (d) Cannot effectively participate in any kind of health care decision making.

11.* Ability to self-administer medications. Based on the preceding review of functional capabilities, physical and cognitive status, and limitations, rate this resident's ability to take his/her own medications safely and appropriately.

- (a) Independently without assistance
- (b) Can do so with physical assistance, reminders or supervision only
- (c) Need to have medications administered by someone else

 Print Name

 Date

 Signature of Health Care Practitioner

 License No. and Category

Resident Name _____

Date Completed _____

Date of Birth _____

PRESCRIBER'S MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Allergies (list all): _____

Note: Does resident require medications crushed or in liquid form? Indicate in 12(a) with medication order. If medication is *not* to be crushed please indicate.

12(a) Medication(s). Including PRN, OTC, herbal, and dietary supplements. Include dosage, route (p.o., etc.), frequency, duration (if limited).	12(b) All related diagnoses, problems, conditions. Please include all diagnoses that are currently being treated by this medication.	12(c) Treatments (include frequency and any instructions about when to notify the physician). Please link diagnosis, condition or problem as noted in prior sections.	12(d) Related testing or monitoring. Include frequency and any instructions to notify physician.

Prescriber's Signature _____

Date _____

Office Address _____

Phone # _____

Signature of RN who has reviewed and reported the above by family, resident, and pharmacy dispensed medication supplied at time of review.

Date _____