



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: \_\_\_\_\_

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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
<b>Cognition</b>					
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	
<b>Communication</b>					
VI. Receptive/expressive aphasia	None	Mild	Moderate	Severe	
<b>Mood and Emotions</b>					
VII. Anxiety	Never	Occasional	Regular	Continuous	
VIII. Depression	None	Mild	Moderate	Severe	
<b>Behaviors</b>					
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 \_\_\_\_\_

Resident Name \_\_\_\_\_

Date Completed \_\_\_\_\_

Date of Birth \_\_\_\_\_

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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 \_\_\_\_\_