ADLs ARE AT TIME OF NH ADMISSION

PATIENT'S NAME: ______________________________

J

SIGHT	☐ 1. Good ☐ 2. Vision adequate – unable to read/see details ☐ 3. Vision limited – gross object differentiation ☐ 4. Blind 5. Glasses: ☐ Yes ☐ No	**AMBULATION**	☐ 1. Independence w/wo assistive device ☐ 2. Walks with supervision ☐ 3. Walks with continuous human suppport ☐ 4. Bed to chair (total help) ☐ 5. Bedfast
HEARING	☐ 1. Good ☐ 2. Hearing slightly impaired ☐ 3. Limited hearing (e.g., must speak loudly) ☐ 4. Virtually/completely deaf	**ENDURANCE**	☐ 1. Tolerates distance (250 feet sustained activity) ☐ 2. Needs intermittent rest ☐ 3. Rarely tolerates short activities ☐ 4. No tolerance
SPEECH	☐ 1. Speaks clearly with others of same language ☐ 2. Some defect – usually gets message across ☐ 3. Unable to speak clearly or not at all	**TRANSFER**	☐ 1. No assistance ☐ 2. Equipment only ☐ 3. Supervision only ☐ 4. Requires human transfer w/wo equipment ☐ 5. Bedfast
COMMUNI-CATION	☐ 1. Transmits messages / receives information ☐ 2. Limited ability ☐ 3. Nearly or totally unable	**WHEELCHAIR USE**	☐ 1. Independent ☐ 2. Assistance in difficult maneuvering ☐ 3. Wheels a few feet ☐ 4. Unable ☐ N/A
MENTAL AND BEHAVIOR STATUS	☐ 1. Alert ☐ 2. Confused ☐ 3. Disoriented ☐ 4. Comatose ☐ 5. Aggressive ☐ 6. Disruptive ☐ 7. Apathetic ☐ 8. Wanders ☐ 9. Safety Restraints Needed ☐ 10. Well Motivated	**TOILETING**	☐ 1. No assistance ☐ A – Bathroom ☐ 2. Assistance to and from and transfer ☐ B – Bedside Commode ☐ 3. Total assistance including personal ☐ 4. Hygiene/help with clothes ☐ C – Bedpan
SKIN CONDITION	☐ 1. Intact ☐ 2. Dry/Fragile ☐ 3. Irritations (rash) Site:__________ ☐ 4. Open Wound Stage:__________ ☐ 5. Decubitus Size:__________	**BLADDER CONTROL**	☐ 1. Continent ☐ 5. Total incontinence ☐ 2. Rarely – e.g., h.s. ☐ 6. Catheter – indwelling ☐ 3. Occasional – once/week or less ☐ 4. Frequent – up to once a day
DRESSING	☐ 1. Dresses self ☐ 2. Minor assistance ☐ 3. Partial help complete half dressing ☐ 4. Has to be dressed	**BOWEL CONTROL**	☐ 1. Continent ☐ 4. Frequent – up to once a day ☐ 2. Rarely – e.g., h.s. ☐ 5. Total incontinence ☐ 3. Occasional – once/week or less ☐ 6. Ostomy
BATHING	☐ 1. No assistance ☐ 2. Supervision only ☐ 3. Assistance ☐ 4. Is bathed ☐ 5. Complete bed bath procedure ☐ A – Tub ☐ B – Shower ☐ C – Sponge Bath	**FEEDING**	☐ 1. No assistance ☐ 2. Minor assistance; needs tray set up only ☐ 3. Help in feeding/encouraging ☐ 4. Is fed ☐ 5. Aspirates
TEACHING NEEDS	☐ 1. Diabetic ☐ 2. Cardiac ☐ 3. Ostomy ☐ 4. Other (specify):	**DIET**	☐ 1. Full ☐ 2. Mechanical Soft ☐ 3. Pureed ☐ 4. Other (specify):

SIGNATURE AND TITLE: DATE:

K PHYSICAL THERAPY:

☐ New Referral ☐ Continuation of Therapy

Frequency of Treatment:______________________________

Treatment Goals

Sensation Impaired: ☐ Yes ☐ No

Restrict Activity: ☐ Yes ☐ No

☐ Stretching	☐ Coordinating Activities	☐ Progress bed to wheelchair
☐ Passive ROM	☐ Non-weight bearing	☐ Recovery to full function
☐ Active assistive	☐ Partial weight bearing	☐ Wheelchair independent
☐ Active	☐ Full weight bearing	☐ Complete ambulation
☐ Progressive resistive		

Precautions:

☐ Cardiac ☐ Other:__________________

L ADDITIONAL THERAPIES: ☐ O.T. ☐ Speech ☐ R.T.

Instructions:____

Signature & Title: Date:

M SOCIAL WORK ASSESSMENT:

Prior Living Arrangement:____

____

Long Range Plan/Agency Referrals:____

____

Adjustment to Illness or Disability:____

____

Signature & Title: Date: