

PRE-ADMISSION SCREEN: FUNCTIONAL ASSESSMENT

PART A: GENERAL INFORMATION

1. APPLICANT NAME: _____

2. CURRENT ADDRESS: _____

3. DATE OF BIRTH: _____

4. MEDICAL DIAGNOSIS: 1. _____

2. _____

3. _____

4. _____

5. _____

5. PARALYSIS (describe): _____

6. CONTRACTURES (describe): _____

7. WOUNDS/DECUBITI (describe): _____

8. MEDIC ALERT: _____

9. ALLERGIES: _____

10. LANGUAGE: _____

11. HANDICAP AIDES: _____

12. RISK OF FALLING: HIGH () LOW ()

13. POTENTIAL SWALLOWING OR CHOKING PROBLEMS:

14. DESCRIBE SKIN INTEGRITY:

15. PAIN (describe location, type and methods utilized to decrease pain): _____

16. SAFETY NEEDS (side rails, restraints etc.):

17. PERSON TO CONTACT FOR FURTHER INFORMATION/VERIFICATION:

NAME: _____

ADDRESS: _____

TELEPHONE No.

(H) _____ (W) _____ Cell No. _____

PART B: LIFE EXPERIENCES:

1. RELIGION: _____

2. EDUCATION: _____

3. WORK EXPERIENCE: _____

4. FAMILY DYNAMICS: _____

5. SOCIAL NETWORK: _____

6. PRIOR LIVING SITUATIONS: _____

7. ABILITIES/ACCOMPLISHMENTS/STRENGTHS: _____

PART C: MENTAL STATUS:

BEHAVIOR	NEVER (√)	SOMETIMES (√)	ALWAYS (√)
ALERT			
IMPAIRED JUDGEMENT			
AGITATED			
HALLUCINATES			
WANDERS			
COMBATIVE			
STRIKES OUT			
ABUSIVE			
OTHER (please explain)			

DOES THE PERSON:

1. Become confused about familiar places (e.g. lose way, aimless wandering, forgetting location of toilets) ___ No ___ Occasionally ___ Frequently

Approximate date of onset: _____

Provide Examples; indicate if the behavior developed recently and describe the situation in which it occurs.

How is the behavior currently managed?

2. Periodically fails to recognize familiar persons or mistakes familiar persons for others?

___ No ___ Occasionally ___ Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

3. Experience significant confusion about time, day of the week, night versus day; time of the year?
___ No ___ Occasionally ___ Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

4. Demonstrate confusion about time of life? (e.g. lapsing into behavior and speech/language associated with past)

___ No ___ Occasionally ___ Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

5. Become upset in stressful situation? (Noise, crowds, visitors, public places etc.)

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

6. Lapse into confused and disoriented speech? (e.g. Rambling, forgetting ordinary words)

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

7. Exhibit undue fear of suspicion of others?

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

8. Accuse others of stealing or hiding property and/or money or of being threatening or causing bodily harm?

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

9. Withdraw or have periods of despair? (e.g. crying, expressing hopelessness through speech, behavior, or facial expressions?)

___ No ___ Occasionally ___ Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

10. Have difficulty getting along with others? (e.g. quarrelsome, uncooperative, irritable, loud or constantly talking, interfering).

___ No ___ Occasionally ___ Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

11. Have episodes of self-destructive or self-abusive behavior?

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

12. Have periods of intensive and apparently unprovoked aggressive acts against others? (e.g. verbal or physical)

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

13. Hoard and hide things inappropriately? (e.g. food, cutlery, linen).

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

14. Have difficulty adhering to normal hygiene practices and dressing appropriately?

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

15. Exhibit inappropriate sexual behavior? (e.g. exhibitionism, public masturbation, inappropriate physical aggressive advances).

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

16. Smoke carelessly?

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

17. Any history of substance abuse?

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

18. Exhibit disruptive or unusual sleep patterns? (e.g. nighttime wandering).

No Occasionally Frequently

Approximate date of onset: _____

Provide Examples:

Current Management:

COMPLETED BY: _____, Position: _____

Clearly print name

SIGNATURE: _____ Date: _____

PART D: DAILY HABITS:

1. Describe daily routine: _____

2. List activities enjoyed: _____

3. ALCOHOL USE ___ NEVER ___ SOMETIMES ___ OFTEN
4. TOBACCO USE ___ NEVER ___ SOMETIMES ___ OFTEN
5. DIETARY RESTRICTIONS: _____
6. FOOD INTOLERANCES/DISLIKES: _____

7. FOOD PREFERENCES: _____
8. DENTURE FIT: ___ N/A ___ GOOD ___ FAIR ___ POOR
9. DIETARY AIDES: _____

PART E: SENSORY ABILITIES:

1. VISION: LEFT EYE: _____
 RIGHT EYE: _____
 2. HEARING: LEFT EAR: _____
 RIGHT EAR: _____
 3. SPEECH ___ SPEAKS CLEARLY ___ DIFFICULT TO UNDERSTAND
 ___ DOES NOT SPEAK AT ALL
- PREFERRED LANGUAGE: _____

PART F: FUNCTIONAL CAPABILITIES:

- 1. AMBULATION Independent without assistive device
- Independent with assistive device
- Walks with difficulty with assistive device
- Walks with assistance of one person
- Walks with assistance of two persons
- Uses wheelchair
- Uses broda chair

Indicate type of assistive device used: _____

- 2. TRANSFERRING: Requires no assistance
- Requires supervision only
- Requires assistive device (specify): _____
- Requires the assistance of 1 person
- Requires the assistance of 2 persons
- Requires the use of mechanical lift

- 3. BATHING No assistance
- TUB OR Supervision only
- SHOWER Partial assistance
- Total assistance

- 4. GROOMING: Self care
- HYGIENE Occasional assistance
- Partial assistance
- Total assistance

- 5. DRESSING No assistance (dresses self)
- Partial assistance
- Total assistance

6. TOILETING:
- Self care
 - Transfer, position equipment, provide cues
 - Partial assistance with hygiene, washing hands
 - Use of one person for transfer, and safety
 - Use of two persons for transfer and safety
 - Does not use toilet, containment with briefs
 - Catheter care
 - Foley
 - Suprapubic

- BLADDER CONTROL:
- Continent
 - Rarely incontinent
 - Occasionally incontinent
 - Dribbles
 - Totally incontinent
 - Catheter
 - Indwelling catheter
 - Condom type catheter
 - Suprapubic catheter
 - Intermittent straight catheter

- BOWEL CONTROL:
- Continent
 - Rarely incontinent
 - Occasionally incontinent
 - Totally incontinent
 - Ostomy care type: _____
 - Self care
 - Assist/total care
 - Laxatives

7. EATING:
- Self feed
 - Requires minimal assistance, set up
 - Needs encouragement or cueing
 - Needs some assistance with eating
 - Needs total assistance
 - Requires tube feed

8. ENDURANCE: ___Tolerates sustained activities
 ___Requires intermittent rest
 ___Barely tolerates short activities
 ___No activity tolerance

9. SLEEP AND REST: ___Sleeps well
 ___Up often during the night
 ___Wanders at night

NURSE ASSESSOR: _____

Signature

TITLE: _____

DATE: _____