



OKLAHOMA
State Department
of Health

Oklahoma State Department of Health
Long Term Care Service
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Recommended Assisted Living
Resident Assessment Form

All Areas Must Be Addressed, "N/A" if not applicable.

* Denotes items required for Admission Assessment.

Admission Date _____

Facility Name _____ Assessment Date _____

Resident Name _____ Room #: _____ Date of Birth: _____

Assessment Type (circle one): Preadmission 14 day Annual Significant Change

*Disease Diagnoses and Medically Defined Conditions:

*History of Infections and Prior Medical History:

*List All Current Medications and dosages (list additional medications on separate page if needed):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Mental /Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) (circle one)

Alert / Non-Alert / Oriented x _____ Confused / Confused at Times / Forgetful Judgment: G / F / P

*Mental Health History / Intellectual or Developmental Disabilities:

*Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Mobility: G / F / P Strength: G / F / P Gait: G / F / P

Range of Motion: Full/Limited / Contractures (describe): _____

Weight Bearing: Yes / No (describe): _____

Ambulatory Without Assistance /With Staff Assistance (describe): _____

Bedfast / Chair fast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

*List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:

Bathing _____ Eating _____ Dressing _____ Transferring _____ Toileting _____ Ambulation _____

Devices/Restraints (Describe): _____

Utilized When and Why (describe): _____

Side rails used? Yes / No

Assisted Living Resident Assessment Form

Oral / Nutritional Status:

Diet Order:_____Height:_____Weight:_____Weight Changes (loss or gain)_____

Abnormalities: Swallowing Problem Yes / No Nausea / Vomiting (describe)_____

Ability to Eat: Independent / Meal Set Up & Cueing / Assistance to Use Utensils/ Supervision / Must be Fed

Oral Status: Own Teeth / Partial Teeth / Dentures / No Teeth / Condition of Teeth (describe)_____

Tube Feeding: Gastrostomy / Nasogastric (describe) _____

***Toileting Ability / Elimination:**

Bladder: Continent / Incontinent / Incontinent at times (describe) / Urinary Catheter - Indwelling / Other

Bowel: Continent / Incontinent / Incontinent at times (describe)_____

Toileting Ability: Independent / Assist / Total Assist / Adult Briefs / B&B Restoration / Toileting Schedule

Customary Routine (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Sleep habits: G / F / P How Many Hours in 24?_____Sleep Problems (describe)_____

Meals: In Dining Room / In Room / Other Location / Eats Out (describe frequency)_____

Bathing: Prefers bath / Prefers shower / Preferred schedule (describe)_____

Usual time to rise_____Usual bedtime_____Naps during day?_____

Psychosocial Status: (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Ability to communicate: G / F / P Interviewable: Yes / No. If No describe: _____

Usual Mood: Calm / Fearful / Agitated / Anxious_____

History of Mood Disorder / Depression:_____

History of Abnormal Behaviors: Agitation / Anger Outburst /Crying / Aggressive / Combative / Elopement Risk

Family / Friends Involvement: Yes / No(describe)_____

Skin Condition (G=Good, F=Fair, P=Poor, if fair or poor, describe):

General Condition: G / F / P_____Turgor: G / F / P_____

Describe Color, Texture and Appearance: _____

Describe Abnormalities: _____

Wounds (Describe All: location, size, color, drainage, treatment):_____

***Screening for signs and symptoms of venous thromboembolism (VTE) [63 O.S. 1-890.3(a)(1)], describe:**

***Describe techniques for providing emergency response to venous thromboembolism (VTE) [63 O.S. 1-890.3(a)(1)]:**

Assisted Living Resident Assessment Form

Special Treatments and Procedures (i.e. wound care, respiratory therapy, physical therapy, restorative, etc.):

Sensory and Physical Impairments (i.e. vision, hearing, etc.):

Signature of Resident or Representative Interviewed

Participating Health Professional Date

**Signature (R.N. or Physician), Title Date*

Participating Health Professional Date