

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

SIGNATURE AND TITLE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHYSICAL THERAPY:**  NEW REFERRAL  CONTINUATION OF THERAPY

FREQUENCY OF TREATMENT \_\_\_\_\_ TREATMENT GOALS: \_\_\_\_\_ SENSATION IMPAIRED:  YES  NO

STRETCHING  COORDINATING ACTIVITIES  PROGRESS BED TO WHEELCHAIR  RESTRICT ACTIVITY:  YES  NO

PASSIVE ROM  NON-WEIGHT BEARING  RECOVERY TO FULL FUNCTION

ACTIVE ASSISTIVE  PARTIAL WEIGHT BEARING  WHEELCHAIR INDEPENDENT

ACTIVE  FULL WEIGHT BEARING  COMPLETE AMBULATION  PRECAUTIONS:  CARDIAC OTHER \_\_\_\_\_

PROGRESSIVE RESISTIVE

**ADDITIONAL THERAPIES:**  O.T.  SPEECH  R.T.

INSTRUCTIONS: \_\_\_\_\_

SIGNATURE & TITLE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**SOCIAL WORK ASSESSMENT:**

PRIOR LIVING ARRANGEMENT \_\_\_\_\_

LONG RANGE PLAN/AGENCY REFERRALS \_\_\_\_\_

ADJUSTMENT TO ILLNESS OR DISABILITY \_\_\_\_\_

SIGNATURE AND TITLE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_