



# RN ASSESSMENT (Optional)

Consumer Name				Case #/SS#	
Date	Facility Name				
DOB	Gender: ( <input checked="" type="checkbox"/> One) <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Race	Date of Admission	Time of Admission
					( <input checked="" type="checkbox"/> One) <input type="checkbox"/> AM <input type="checkbox"/> PM
Transported By: <input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Ambulance <input type="checkbox"/> Other _____		Received From:	Accompanied By:	Relationship	

## MEDICAL HISTORY

Name of PCP/CRNP(s):					
Phone #s:	( )	( )			
Other Physicians:					
Date of Last Visit:		Location			
Date of Last TB Skin Test or CXR		Result			
Vital Signs	T _____	P _____	R _____	BP _____	Arm: <input type="checkbox"/> R <input type="checkbox"/> L
Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Menstrual Period		
Allergies	<input type="checkbox"/> None <input type="checkbox"/> Medication(s) _____ <input type="checkbox"/> Food(s) _____ <input type="checkbox"/> Other _____				
Pain	<input type="checkbox"/> None				
	Location(s)				
	Frequency	<input type="checkbox"/> Daily	<input type="checkbox"/> Daily/Intermittent	<input type="checkbox"/> Constant	<input type="checkbox"/> Other
	Intensity	<input type="checkbox"/> Mild	<input type="checkbox"/> Distressing	<input type="checkbox"/> Severe	<input type="checkbox"/> Unbearable
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Describe		
	Pain on Admission _____				

Special Treatments/Procedures/ Equipment (List all including purpose):	<input type="checkbox"/> None
Past Surgeries/Implants (list all including year and location):	<input type="checkbox"/> None
Past Psychiatric/Medical Hospitalizations (List all including year/location/reason):	<input type="checkbox"/> None

FAMILY / RELATIONSHIPS				<input type="checkbox"/> None
Marital Status	Children	Parents	Siblings	Significant Others
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other	<input type="checkbox"/> Yes Number: ____  <input type="checkbox"/> No	Mother <input type="checkbox"/> Alive <input type="checkbox"/> Deceased  Father <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> None  <input type="checkbox"/> Yes/# # Alive ____ # Deceased ____	Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No  Name _____  Friend(s) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other

RELIGIOUS/SPIRITUAL/CULTURAL	
Religious Affiliation	
Attend Church?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cultural/Ethnic Practices That Impact Care/Teaching (List)	

CURRENT STATUS		
PHYSICAL LIMITATIONS		
	Site	Degree
Paralysis/paresis		
Contracture(s)		
Congenital Anomalies		
Prosthesis		
Other		

FUNCTIONAL ABILITY			
AMBULATION	WEIGHT BEARING	TRANSFERS	SUPPORTIVE DEVICES
<input type="checkbox"/> Independent <input type="checkbox"/> 1 Person Assist <input type="checkbox"/> 2 Person Assist <input type="checkbox"/> With Device ( <i>name</i> ) _____ <input type="checkbox"/> WC only <input type="checkbox"/> WC Propels Self	<input type="checkbox"/> Full Weight <input type="checkbox"/> Partial Weight <input type="checkbox"/> Non-Weight Bearing	<input type="checkbox"/> Independent <input type="checkbox"/> 1 Person Assist <input type="checkbox"/> 2 Person Assist <input type="checkbox"/> Total Dependence	<input type="checkbox"/> Elastic Hose <input type="checkbox"/> Hand Rolls <input type="checkbox"/> Sheepskin <input type="checkbox"/> Other ( <i>list</i> ) _____ _____ _____

**GENERAL SKIN CONDITION:** (*Check all that apply*)

	SITE		SITE
<input type="checkbox"/> Dry		<input type="checkbox"/> Oily	
<input type="checkbox"/> Edematous		<input type="checkbox"/> Cyanotic	
<input type="checkbox"/> Pale		<input type="checkbox"/> Warm	
<input type="checkbox"/> Moist		<input type="checkbox"/> Cold	
<input type="checkbox"/> Reddened		<input type="checkbox"/> Jaundiced	
<input type="checkbox"/> Ashen		<input type="checkbox"/> Other	

Hearing	R	L	Vision	R	L	Speech
<input type="checkbox"/> Adequate			<input type="checkbox"/> Adequate			<input type="checkbox"/> Clear
<input type="checkbox"/> Poor			<input type="checkbox"/> Poor			<input type="checkbox"/> Aphasic
<input type="checkbox"/> Deaf			<input type="checkbox"/> Blind			<input type="checkbox"/> Dysphasic
<input type="checkbox"/> Hearing Aid			<input type="checkbox"/> Glasses/Contacts			Language: _____

Oral	Eating/Nutrition	Sleep	Bathing/ Grooming	Indep	Assist	Dep
<input type="checkbox"/> Own Teeth ( <i>Note condition</i> )  <b>DENTURES</b> <input type="checkbox"/> Partial <input type="checkbox"/> Upper <input type="checkbox"/> Lower  <b>Fit</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assist <input type="checkbox"/> Dysphasic ( <i>reason</i> ) _____  <input type="checkbox"/> Adaptive Equipment ( <i>type</i> )  <input type="checkbox"/> Diet ( <i>Consistency</i> )	Usual Bedtime _____  Usual Arising Time _____  <b>Nap</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tub <input type="checkbox"/> Shower <input type="checkbox"/> Bed Bath  Oral Hygiene  Shave  Shampoo Grooming Dressing			

**BOWEL AND BLADDER EVALUATION**

<b>Bowel Continent</b>		<b>Bladder Continent</b>		<b>Frequent Constipation</b>	
Other:		Other:			
<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N

**PSYCHOSOCIAL FUNCTIONING**

<b>Oriented</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Person <input type="checkbox"/> Situation	<input type="checkbox"/> Place <input type="checkbox"/> Facility	<input type="checkbox"/> Time
<b>General Appearance</b>	<input type="checkbox"/> Dressed/groomed appropriately for age/sex/situation <input type="checkbox"/> Disheveled <input type="checkbox"/> Pale <input type="checkbox"/> Emaciated <input type="checkbox"/> Sad <input type="checkbox"/> Happy			
<b>Level of Consciousness/ Behavior</b>	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Expressionless <input type="checkbox"/> Cooperative <input type="checkbox"/> Rigid/Tense	<input type="checkbox"/> Responsive <input type="checkbox"/> Hyperactive <input type="checkbox"/> Combative <input type="checkbox"/> Tics/Tremors <input type="checkbox"/> Hostile <input type="checkbox"/> Compulsive	<input type="checkbox"/> Joyful <input type="checkbox"/> Pacing <input type="checkbox"/> Calm <input type="checkbox"/> Other	
<b>Speech</b>	<input type="checkbox"/> Talkative <input type="checkbox"/> Nonverbal <input type="checkbox"/> Loud <input type="checkbox"/> Other	<input type="checkbox"/> Forced <input type="checkbox"/> Slurred <input type="checkbox"/> Illogical	<input type="checkbox"/> Pressured/Excessive <input type="checkbox"/> Impediment <input type="checkbox"/> Monosyllabic	<input type="checkbox"/>
<b>Affect/Mood</b>	<input type="checkbox"/> Appropriate <input type="checkbox"/> Anxious <input type="checkbox"/> Flat <input type="checkbox"/> Angry <input type="checkbox"/> Friendly	<input type="checkbox"/> Depressed <input type="checkbox"/> Guarded <input type="checkbox"/> Cooperative <input type="checkbox"/> Other	<input type="checkbox"/> Elated <input type="checkbox"/> Uncooperative	
<b>Thoughts</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Guarded <input type="checkbox"/> Wandering <input type="checkbox"/> Illusions <input type="checkbox"/> Homicidal	<input type="checkbox"/> Flighty <input type="checkbox"/> Disorganized <input type="checkbox"/> Delusional <input type="checkbox"/> Suicidal	<input type="checkbox"/> Paranoid <input type="checkbox"/> Hallucinations <input type="checkbox"/> Other	
<b>Memory</b>	<input type="checkbox"/> Remote Memory (past) <input type="checkbox"/> Recent Memory	<input type="checkbox"/> Delayed Recall (repeat after 5 minutes) <input type="checkbox"/> Attention Level (ability to concentrate)		
<b>Insight</b>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <i>(What is causing your problem? What causes you to be here today?)</i>			
<b>Judgment</b>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <i>(What would you do if you ran out of meds?)</i>			
<b>Personal Habits</b>	Smokes Cigarettes/Cigar/Pipe <input type="checkbox"/> Yes / <input type="checkbox"/> No Frequency	Drinks Alcohol <input type="checkbox"/> Yes / <input type="checkbox"/> No Frequency	Illegal Drug Use <input type="checkbox"/> Yes / <input type="checkbox"/> No Frequency	
<b>Family Support</b>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<b>Family Relationship</b>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	



**THIS SECTION TO BE COMPLETED BY RN ONLY**

**Analysis of Subjective/Objective Data:**

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**Summary of Consumer Needs: (Select all that apply)**

- Skilled Nursing Only**
- MAC Worker Assistance with MAS Nurse Supervision 24/7
- Monitor psychiatric status (frequency)
- Monitor medical/physical status (frequency)
- Referral to:
  - PCP
  - Dentist
  - Optometrist
  - Other \_\_\_\_\_
- Other (Explain) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Nursing Interventions: (Select all that apply)**

- Skilled Nursing
- MAS Nurse Supervision of MAC Worker
- Lab (test/frequency) \_\_\_\_\_
- Reassessment/Evaluation \_\_\_\_\_ (frequency)
- Referral to service not provided by agency \_\_\_\_\_ (list)
- Other (Explain)

**RN SIGNATURE**

**DATE**

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