



**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 / Mental Retardation 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):**

Side rails used? Yes / No

Restraint Devices (Describe) \_\_\_\_\_ Utilized When and Why (describe) \_\_\_\_\_

**Assisted Living Resident Assessment Form**

**Oral / Nutritional Status:**

Diet Order: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight Changes (loss or gain) \_\_\_\_\_

Abnormalities: Swallowing Problems 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): \_\_\_\_\_

**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*