INITIAL IN-HOUSE ASSESSMENT

(OPTIONAL PRE-SERVICE PLAN ASSESSMENT)

This form is to be completed by the resident manager during the first couple days of admission. This initial assessment maybe utilized by the individual completing the care plan if desired.

Resident Name: _____ Date: _____

Date of Admission: _____

Current Weight: _____ Height: _____

GENERAL ASSESSMENT OF FUNCTIONAL LEVEL

1. Dietary:

Special Diets: _____

Food Allergies: _____

Food Preferences: _____

Food Dislikes/Intolerance: _____

What level of assistance is required for eating?

Independent: ☐ YES ☐ NO Cuing: ☐ YES

Dependent: ☐ YES ☐ NO ☐ NO

Does the resident use or might benefit from and specifically adapted eating utensils? _____

Other Information: _____

2. Ambulance and Transfers:

Is the resident ambulatory? ☐ YES ☐ NO

Does the resident use a walker? ☐ YES ☐ NO

Wheelchair? ☐ YES ☐ NO

Other assistive devices? ☐ YES ☐ NO

What level of assistance is required for ambulation? _____

What level of assistance is required for transfers? _____

Problems and other information: _____

3. Toileting:

Is the resident incontinent of bowel? ☐ YES ☐ NO

Bladder? ☐ YES ☐ NO

Does the resident have a catheter? ☐ YES ☐ NO

Ostomy? ☐ YES ☐ NO

Does the Physician require any special monitoring of bowel or bladder? _____

_____

Other information: _____

_____