



Patient Assessment

NF Transition/Diversion

Patient Information			
First Name:		Last Name:	
CIN #:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say	
Age:	DOB:	Height:	Weight:
Language:		Translator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home/Current St:		City, State, Zip:	
Phone:		Okay to text? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:			

Check this box if patient is own responsible party

DPOA/Responsible Party		
First Name:		Last Name:
Language:	Phone:	Okay to text? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Okay to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship: <input type="checkbox"/> Guardian/Conservator <input type="checkbox"/> HC-POA <input type="checkbox"/> F-POA <input type="checkbox"/> Responsible Payee <input type="checkbox"/> Family Member		

Family/Friend/Caregiver Contact #1		
First Name:		Last Name:
Language:	Phone:	Okay to text? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Okay to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship: <input type="checkbox"/> Guardian/Conservator <input type="checkbox"/> HC-POA <input type="checkbox"/> F-POA <input type="checkbox"/> Responsible Payee <input type="checkbox"/> Family Member		

Family/Friend/Caregiver Contact #2		
First Name:	Last Name:	
Language:	Phone:	Okay to text? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Okay to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship: <input type="checkbox"/> Guardian/Conservator <input type="checkbox"/> HC-POA <input type="checkbox"/> F-POA <input type="checkbox"/> Responsible Payee <input type="checkbox"/> Family Member		

Family/Friend/Caregiver Contact #3		
First Name:	Last Name:	
Language:	Phone:	Okay to text? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email:	Okay to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship: <input type="checkbox"/> Guardian/Conservator <input type="checkbox"/> HC-POA <input type="checkbox"/> F-POA <input type="checkbox"/> Responsible Payee <input type="checkbox"/> Family Member		

Any Family/Relationship Dynamics of note?

Personality	
<input type="checkbox"/> Extrovert <input type="checkbox"/> Introvert <input type="checkbox"/> Reclusive <input type="checkbox"/> Enjoys large groups <input type="checkbox"/> Enjoys small groups <input type="checkbox"/> Prefers one-on-one engagement	
Favorite things to do:	
Greatly dislikes doing these things:	
Spiritual Preference:	<input type="checkbox"/> Would like to attend spiritual activities
Prefers to be called:	
Favorite Color:	Favorite Music/Band/Artist:
Favorite Music/Band/Artist:	
Hobbies:	
Previous Career/Profession:	Preferred Geographic Area:

Notes on PERSONALITY section:

Clinical Providers

PCP:

Phone:

Preferred Contact Method: Phone Email

Email:

Fax:

Specialist:

Phone:

Preferred Contact Method: Phone Email

Email:

Fax:

Dentist:

Phone:

Preferred Contact Method: Phone Email

Email:

Fax:

Other:

Phone:

Preferred Contact Method: Phone Email

Email:

Fax:

Other:

Phone:

Preferred Contact Method: Phone Email

Email:

Fax:

Financial	
Monthly Income: \$ _____	<input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> SDI <input type="checkbox"/> Other: _____
Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Branch of Military: _____
Spouse Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Branch of Military: _____
Recipient of VA Benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes: 	
Any family support? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family willing to contribute funds? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount: \$ _____
Willing to pay 90% of income towards room & board? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____	

Programs	
Programs/Enrolled in: <input type="checkbox"/> MSSP <input type="checkbox"/> IHSS <input type="checkbox"/> ADHC <input type="checkbox"/> ADC (Social Model) <input type="checkbox"/> Linkages <input type="checkbox"/> SUD Therapy Center <input type="checkbox"/> Support Groups <input type="checkbox"/> Agencies <input type="checkbox"/> Mental Health Agency <input type="checkbox"/> 12 Step: _____	
Program #1	
Program Name: _____	Program Director: _____
Contact: _____	
Program #2	
Program Name: _____	Program Director: _____
Contact: _____	
Program #3	
Program Name: _____	Program Director: _____
Contact: _____	

Cultural ConsiderationsCultural Affiliations? Yes No

Notes:

Restrictions? Yes No

Notes:

Needs/Requirements? Yes No

Notes:

Concerns/Items of note? Yes No

Notes:

Ethnicity/National Origin ConsiderationsAffiliations? Yes No

Notes:

Restrictions? Yes No

Notes:

Needs/Requirements? Yes No

Notes:

Concerns/Items of note? Yes No

Notes:

Religion/Creed/Personal Belief ConsiderationsAffiliations? Yes No

Notes:

Restrictions? Yes No

Notes:

Needs/Requirements? Yes No

Notes:

Concerns/Items of note? Yes No

Notes:

Personal Areas of Concern or Areas of Apprehension to Receiving Services

Caregiver gender preference? Yes No

Notes:

Restrictions? Yes No

Notes:

Needs/Requirements? Yes No

Notes:

Concerns/Items of note? Yes No

Notes:

Health Records *(Upload to patient record.)*

H&P PT/OT Notes Current Nursing/MD Notes Med List Advanced Directive

Cognitive/Dementia/Capacity Notes Polst Other Notes

1. Primary Diagnosis

Treatment/medication (type and dosage)/equipment:

Can patient manage own treatment/medication/equipment? Yes No

If not, what type of medical supervision is needed?

2. Secondary Diagnosis

Treatment/medication (type and dosage)/equipment:

Can patient manage own treatment/medication/equipment? Yes No

If not, what type of medical supervision is needed?

Check if applicable to 1 or 2 on Previous Page

Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a “conditional state” between normal aging and dementia.

Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual’s ability to perform activities of daily living or to carry out social or occupational activities.

3. Contagious/Infectious Disease

Treatment/medication (type and dosage)/equipment:

Can patient manage own treatment/medication/equipment? Yes No

If not, what type of medical supervision is needed?

4. Allergies

Treatment/medication (type and dosage)/equipment:

Can patient manage own treatment/medication/equipment? Yes No

If not, what type of medical supervision is needed?

5. Other Conditions

Treatment/medication (type and dosage)/equipment:

Can patient manage own treatment/medication/equipment? Yes No

If not, what type of medical supervision is needed?

Physical Health Status	Yes	No	Assistive Device	Explain
Auditory Impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Wears Dentures	<input type="checkbox"/>	<input type="checkbox"/>		
Wears Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>		
Special Diet	<input type="checkbox"/>	<input type="checkbox"/>		
Substance Abuse Problem	<input type="checkbox"/>	<input type="checkbox"/>		
Use of Alcohol	<input type="checkbox"/>	<input type="checkbox"/>		
Use of Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>		
Bowel Impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Bladder Impairment	<input type="checkbox"/>	<input type="checkbox"/>		
Motor Impairment/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>		
Requires Continuous Bed Care	<input type="checkbox"/>	<input type="checkbox"/>		
History of Skin Condition or Breakdown	<input type="checkbox"/>	<input type="checkbox"/>		
Dental Issues	<input type="checkbox"/>	<input type="checkbox"/>		
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		

Mental Health Condition	Yes	No	Explain
Confused/Disoriented	<input type="checkbox"/>	<input type="checkbox"/>	
Inappropriate Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Wandering Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Sundowning Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Follow Instructions	<input type="checkbox"/>	<input type="checkbox"/>	
Depressed	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal/Self-Abusive	<input type="checkbox"/>	<input type="checkbox"/>	

*MENTAL HEALTH CONDITION continued on next page...

Able to Communicate Needs	<input type="checkbox"/>	<input type="checkbox"/>	
At Risk if Allowed Direct Access to Personal Grooming & Hygiene Items	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Leave Facility Unassisted	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	

Capacity for Self-Care	Yes	No	Explain
Able to Bathe Self	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Dress/Groom Self	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Feed Self	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Care for Own Toileting Needs	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Manage Own Cash Resources	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	

Medication Management	Yes	No	Explain
Able to Administer Own Prescription Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Administer Own injections	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Perform Own Glucose Testing	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Administer Own PRN Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Administer Own Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Store Own Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	

Other Treatments	Yes	No	Explain
<u>Urinary Catheter</u> <input type="checkbox"/> Patient Independent <input type="checkbox"/> Staff/Assistance Required <input type="checkbox"/> Bed/Chair Bag <input type="checkbox"/> Leg Bag <input type="checkbox"/> Indwelling <input type="checkbox"/> Intermittent	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Colostomy</u> <input type="checkbox"/> Patient Independent <input type="checkbox"/> Staff/Assistance Required	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Ileostomy</u> <input type="checkbox"/> Patient Independent <input type="checkbox"/> Staff/Assistance Required	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Tracheostomy</u> <input type="checkbox"/> Patient Independent <input type="checkbox"/> Staff/Assistance Required	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Gastrostomy</u> <input type="checkbox"/> Patient Independent <input type="checkbox"/> Staff/Assistance Required	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Enema/Suppository</u> <input type="checkbox"/> Patient Independent <input type="checkbox"/> Staff/Assistance Required	<input type="checkbox"/>	<input type="checkbox"/>	
<u>CPAP</u> <input type="checkbox"/> Patient Independent <input type="checkbox"/> Staff/Assistance Required	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Other:</u> _____ <input type="checkbox"/> Patient Independent <input type="checkbox"/> Staff/Assistance Required	<input type="checkbox"/>	<input type="checkbox"/>	

Pain Management

Chronic Pain? Yes No

Location of Pain:

Cause:

Pain Meds:

Is Patient in pain now? Yes No What number on Pain Scale? _____

Other types of Pain Management:

Ambulatory Status

This person is able to independently transfer to and from bed: Yes No

For purposes of a fire clearance, this person is considered:

Ambulatory Nonambulatory Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and/or a person who depends upon mechanical aids such as crutches, walkers, and wheelchairs.

NOTE: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered nonambulatory for the purposes of fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

If resident is nonambulatory, this status is based upon:

Physical Condition Mental Condition Both Physical and Mental Condition

If resident is bedridden, check one or more of the following and describe the nature of the illness, surgery, or other cause:

Illness: _____

Recovery from Surgery: _____

Other: _____

**AMBULATORY STATUS continued on next page...*

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

If resident is bedridden, how long is bedridden status expected to persist?

_____ (number of days)

Estimated date illness or recovery is expected to end or when resident will no longer be confined to bed:

If illness or recovery is permanent, please explain:

ADL AND IADL

COMMUNICATION

Usually able to communicate:

Notes: _____

Occasionally able, but frequent difficulty to make simple requests regarding needs and preferences:

Notes: _____

Occasionally able, but frequent difficulty to respond to simple & direct questions & directions:

Notes: _____

Rarely or never able, and/or very-limited ability to communicate – Someone else must interpret sounds or body language:

Notes: _____

Problems with speech clarity:

Notes: _____

Uses sign language, reads lips or utilizes communication device:

Notes: _____

Language or cultural issue barrier to communication. Primary Language:

Notes: _____

AMBULATION/MOBILITY No assistance needed

Uses the following:

 Cane Crutch Walker Wheelchair Electric Wheelchair Scooter Ambulatory Nonambulatory Bedridden: _____ Needs escorting/Stand-by assist for ambulation: _____At risk for wandering? Yes No

Notes: _____

Ambulation limited to _____ feet.

Limitation due to: _____

 Able to ascend and descend stairs but requires stand-by assist or assistive devices:

Notes: _____

 Unable to ascend and descend stairs regardless of assistance or device:

Notes: _____

TRANSFERS

Patient transfers:

 Independently Requires 1 person Requires 2 persons Requires mechanical lift Slide board Requires another device for transferring: _____Requires stand-by assist for safe transfers? Yes No

Notes: _____

BED MOBILITY

- No assistance needed Requires cueing or encouragement
 Able to turn or reposition but requires help or guidance
 Able to assist, requires one person to support while moving or lifting
 Dependent on one person to turn or reposition
 Dependent on more than one person to turn or reposition
 Reposition ever _____ hours Day time Night time Trapeze Wedge Foot cradle
 Rails Hoyer Draw sheet Hospital bed Special mattress: _____
 Notes: _____

BATHING/SHOWERING

- Independent Requires assistance
 Notes: _____

DRESSING

- Dresses independently Requires assistance to select clothing Requires lower body dressing
 Requires upper body dressing Requires assistance with shoes, bra, buttons, snaps
 Requires help with compression socks Replace buttons with Velcro®
 Elastic waist pants Requires 2-person assistance with dressing
 Notes: _____

GROOMING

- Independent with grooming tasks
 Reminders for: Hair brushing Oral care Makeup Shaving
 Notes: _____
 Requires set-up for: Hair brushing Oral care Makeup Shaving
 Notes: _____

*GROOMING continued on next page...

Minimal assistance for: Hair brushing Oral care Makeup Shaving

Notes: _____

Moderate assistance for: Hair brushing Oral care Makeup Shaving

Notes: _____

Total assistance for: Hair brushing Oral care Makeup Shaving

Notes: _____

DIET

Regular Diet: The Regular Diet is planned to meet nutritional needs of the older adult. It offers variety and reflects regional, cultural and religious eating patterns. There are no restrictions with the Regular Diet.

Notes:

Mechanical Soft: The Mechanical Soft is a Regular Diet that is modified to be softer. Only texture and consistency of food is changed. Fruits and vegetables may be soft-cooked or pureed. Meats, fish, and poultry can be cooked, ground, and moistened with sauce or gravy to make chewing and swallowing more comfortable. The Mechanical Soft Diet is appropriate for patients who are recovering from head, neck and mouth surgery, who have dysphagia (difficulty swallowing), narrowing of the esophagus (food tube), or who are too ill or weak to chew. The diet also benefits those who have poorly fitting dentures, no teeth, or other dental problems.

Notes:

Pureed: The Pureed Diet is the Regular Diet that has been modified to have a soft, pudding-like consistency. It offers pureed, homogenous, and cohesive foods. All foods that require chewing, controlled manipulation, or bolus formation are excluded.

Notes:

**DIET continued on next page...*

NAS (No Salt Added): The NAS Diet is the Regular with no added salt at the table. There are no foods restricted on the Regular Diet, thus there might be some high sodium foods on the NAS Diet.

Notes:

2 gm Sodium: The 2 gm Sodium Diet restricts the sodium to no more than 2000 mg per day. Since food intake decreases as part of the normal aging process, the restrictive 2 gm Sodium Diet should be used with care with the older adults.

Notes:

Low Concentrated Sweets: The Low Concentrated Sweets Diet helps control blood sugar levels by eliminating most simple sugars (concentrated sweets) in food. Most simple sugars are considered concentrated sweets. Simple carbohydrates cause a quick increase in blood sugar. A Low Concentrated Sweets Diet means avoiding foods with a lot of sugar or high calorie sweeteners.

Notes:

Finger Food: The Finger Food Diet provides nutritionally balanced meals in a form that can be eaten by hand without difficulty.

Notes:

Thickened Liquids:

Nectar thick liquids Honey thick liquids

Notes:

Other:

ORAL ISSUES

- Upper Dentures Lower Dentures Partial Upper Partial Lower Missing Teeth
- Broken/Loose Teeth Inflamed/Bleeding Gums Dry Mouth
- Pain? _____

EATING

- Significant weight LOSS > 10% in last 6 months Significant weight GAIN > 10% in last 6 months

Current Weight: _____

- Requires monitoring, encouragement and/or cueing
- Requires set-up (including cutting meat and opening containers)
- Requires hands-on assistance to guide hand or to drink
- Dependent on assistance for part of a meal or whole meal
- Dependent on assistance for all foods and fluids
- Therapeutic Diet: _____
- Supplements: _____
- Mechanically Altered: _____
- Adaptive Equipment: _____
- Chewing/Swallowing/Choking/Aspiration Issues: _____
- Feeding Tube: _____
- Feeding Frequency: _____

DINING

- Big eater Small appetite Regular appetite – Prefers small portions

Favorite Foods: _____

Food Dislikes: _____

Food Allergies: _____

**DINING continued on next page...*

Favorite Restaurants: _____

Special Utensils

Notes: _____

Cut-up meals ahead of time

Notes: _____

Other Special Dining Requests

Notes: _____

Provide multiple snacks throughout the day

Notes: _____

6 small meals rather than 3 large meals

Notes: _____

Is resident receiving hospice care? Yes No

If YES, specify the terminal illness: _____

Physical Health Status: Good Fair Poor

Comments:

Medication	Strength/Dose/Route/Frequency	Symptom/Reason/Diagnosis	Max Dose in 24 Hours
Signature / Title:		Date:	
Printed Name:		Phone:	