



Nursing Facility: _____ Date: _____

Facility Contact: _____ NF Phone: _____

NF Address: _____ NF Facsimile #: _____

Resident: _____ Physician: _____

Social Security # _____ Physician's Address _____

Medicaid I.D. Number _____ Physician's Address _____

Is Spouse living at home? Yes _____ No _____ Physician's Phone # _____
 Physician's FAX # _____

Admit Date _____ Anticipated length of stay? Remainder of life _____ Six months or less _____ More than six months _____

Is there a discharge plan in place? Yes _____ No _____ Expected discharge date _____

Recipient's Responsible Party:	Name: _____ Relationship _____
	Address: _____

Problem Areas	Describe Problem(s)
Confusion: describe, if disoriented to time, place, include frequency, severity	
Contact with reality: use only if has documented psychiatric diagnosis. Include problem with hallucinations, delusions, freq.	
Behavior problems: describe. Include Places self in danger, verbally abusive, disruptive behavior	
Communication problems: describe ability to communicate basic needs, perform simple commands.	
Mobility problems: describe assistance. Include number of people needed to help, devices, how often and when.	
Bathing problem: describe. Whether assistance required, i.e., in and out of tub, standby, verbal prompts.	
Dressing problems: describe assistance required, i.e., buttons, clothes selection, zippers, willingness, and appropriateness	
Eating/Feeding: describe assistance required, how often, what type, tube feeding, spoon-fed, etc.	
Bowel/Bladder incontinence: describe, frequency of problem, specific training programs and assistance	
Vision problems: describe if corrected by glasses, type of print that can be read, able to function in environment, safety problems.	
Hearing problems: describe if required aid, problem with aids, hears altered volume tones.	
Supervision required: problem that requires medical and/or professional care not stated above.	