

CENTER NAME: _____

PARTICIPANT ASSESSMENT

Admission Assessment _____

Annual Assessment _____

DEMOGRAPHIC/SOCIAL INFORMATION			Section 1
(This section to be completed by center)			
Participant's Name		Nickname	
Address (Pre admission)		DOB	
		SEX	M F
Admission From: (circle one & identify)	Home	Hospital	Other
Language Spoken		Marital Status	M D W S
Participant's Former Occupation		Religious Preference	
Participant's Hobbies/Interests			
Responsible Party Legal Representative		Phone Number	
Address			
Relationship (Circle all that apply)	Spouse	Child POA	Sibling MPOA
		Other DPOA	Guardian
			Committee
Other Care Providers (Dentist, Podiatrist, etc)			

MEDICAL/HEALTH ASSESSMENT		Section 2
Admission Diagnosis		
Allergies		
Medical Assessment		
Date Completed _____		
Skin Condition		
Skin Breakdown		
Decubitus (Size, Location, Treatment)		
Diet	Activity	

Other Services and Treatment Orders (Oxygen, PT, OT, Home Health, Hospice, etc)		
Current Medications (including over the counter)		
Is Participant Capable of Administering Own Medications? (Must be able to read and understand medication labels and meds taken)	Y	N
TB Screening (Date and Results)		
Previous Positive-give presence or Absence of symptoms		
Can services be met in Medical Adult Day Care	Y	N
Participant Requires Sleep Time Supervision	Y	N
Advance Directive	Y	N

FUNCTIONAL LEVEL						Section 3
Sight	Not Impaired		Impaired		Blind	
Hearing	Not Impaired		Impaired		Deaf	
Speech	Not Impaired		Impaired		Aphasic	

ACTIVITIES OF DAILY LIVING						
	Self	With Assistance		Total Assist	Comments	
Eating						
Bathing						
Dressing						
Toileting						
Urinary	Continent		Incontinent		Catheter	
Bowel	Continent		Incontinent		Colostomy	
Mobility	Ambulatory		Cane/Walker		Wheelchair	
Mobility Assistance		1 person		2 person	Total Assist	

PSYCHOSOCIAL/BEHAVIORIAL LEVEL**Section 4**

	Never	Occasionally	Frequently	Comments
Wanders				
Noisy				
Disoriented				
Displays inappropriate behavior (Identify behavior)				
Withdrawn/Depressed				
Combative				
Delusional				
Impaired Judgment (explain)				
Outside Services (Agency)				

To the best of my knowledge, the patient's medical, functional level and psychosocial needs are as indicated above.

Physician's Printed Name

Phone Number

Physician's Signature

Assessment Date