Parker Place Living Centers Pre-Admission Assessment

Resident Name: _____ Rm. Number: _____

Date: _____ Move-in Date: _____

The assessment of the service needs is based on the resident's capabilities, decisions and preferences in the indicated areas.

Medication Assistance:
❑ Self administers all medications ❑ Needs supervision and reminders for self-medication
❑ Requires all medication to be administered by staff

Pharmacy: _____ Phone: _____

Drug Allergies: _____

Precautions or comments: _____

Toileting:
❑ Independent ❑ Needs minimal assistance with clothing
❑ Needs assistance with continence items ❑ Dependent for all toileting needs

Comments: _____.

Continence:
❑ Continent ❑ Bladder incontinence ❑ Bowel incontinence
❑ Occasionally incontinent of bladder ❑ Occasionally incontinent of bowel
❑ Ostomy ❑ Requires assistance with ostomy care

Special instructions: _____.

Night time preparations: _____.

Hygiene Assistance
❑ Requires assistance with morning dressing
❑ Requires assistance with morning bathing and grooming
❑ Requires assistance with night dressing
❑ Requires assistance with night bathing and grooming
❑ Requires minimal assistance with bathing
❑ Requires full assistance with bathing

Requires assistance with: ❑ Dental Care ❑ Bathing or showering ❑ Hearing aids
❑ Glasses ❑ Dressing ❑ Shaving ❑ Hair care ❑ Nail Care

Escorting: ❑ Independent ❑ Requires reminding to attend meals and activities
❑ Requires escort to meals and activities

Assistive Devices
❑ Hearing Aid ❑ Glasses ❑ Cane ❑ Walker ❑ Wheelchair ❑ Scooter
❑ Splint ❑ Brace

Dietary Needs
❑ No special needs ❑ No concentrated sweets ❑ No added salt ❑ Low fat

❑ Calorie Restrictions: _____
❑ Specific Dislikes: _____.
❑ Food Allergies: _____.
❑ Preferences: _____.

Dining Assistance
❑ Independent ❑ Needs Assistance ❑ Dependent

Safety
Describe any conditions that may require the resident to have an apartment located near an exit:
_____.

Housekeeping and Laundry
❑ Independent ❑ Needs assistance ____ times per week ❑ Dependent

Requires the following assistance: ❑ Bed making daily ❑ Bed linen change____X per week
❑ Sweeping ❑ Vacuum ❑ Mopping ❑ Clean bathroom ❑ Clean kitchen
❑ Complete housekeeping assistance daily

Mental Abilities and Orientation

Indicate any problems, needs, reminders or needs for the staff to monitor specific behaviors (wandering, confusion, etc.)_____

_____.

Health Needs
Describe the level of assistance required for physician appointments, routine medical needs, nursing tasks, etc._____

_____.

Behavior Monitoring Needs. Describe any behavioral characteristics that require monitoring.

_____.

Family Support. List the names and phone numbers of family members likely to visit:

_____ _____

_____ _____

_____ _____

_____ _____

Socialization Habits. Indicate hobbies, special interests and desires to socialize with others:
__

_____.

Transportation Needs: _____.
❑ Facility transportation ❑ Public Special Van ❑ Family will transport
❑ Has own car ❑ Arrange with family before other transportation arrangement

Business Management:
❑ Manages all business matters ❑ Family member (name) _____

❑ Advocate (name) _____.

Special Needs: _____.

Life Value Issues:

❑ Full Code ❑ DNR ❑ Living Will ❑ Advance Directives

The resident must comply with all state regulations regarding governing of these medial wishes.

_____ _____
Signature of person completing form Title