**Initial Assessment and History – Long Term Care**

<table>
<thead>
<tr>
<th>Date/Time of Initial Assessment:</th>
<th>Mode of Arrival to Site:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>□ Walking □ Walker</td>
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<table>
<thead>
<tr>
<th>Language(s) spoken/understood:</th>
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<tbody>
<tr>
<td>□ En □ Fr</td>
<td>□ Wheelchair □ Stretcher</td>
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<tr>
<td>□ Other:</td>
<td>□ Other:</td>
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<table>
<thead>
<tr>
<th>Source of Information:</th>
<th>Age:</th>
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<tbody>
<tr>
<td>□ Pre-Initial Assessment</td>
<td></td>
</tr>
<tr>
<td>□ Self</td>
<td></td>
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<tr>
<td>□ Family</td>
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<tr>
<td>□ Other:</td>
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</tbody>
</table>

Name you wish to be called:

Primary Lifetime Occupation: Education:

Reason for Move-in:

**Allergies:**
- (describe reaction(s)) □ None Known
- □ Medi Alert on
- □ Site-specific allergy/intolerance record completed
- □ Agency Alert on
- □ Drug:
- □ Food:
- □ Latex:
- □ Environment:

**Advanced Care Plan (Health Care Directives):**
- □ No
- □ Yes
- □ On file

Other contacts: (name, relationship, phone #s) 1.
2.

**Financial Power of Attorney:**

### Resident’s Response and Interviewer’s Comments

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td><strong>Personal Care</strong></td>
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<tr>
<td>Bathing assistance (help needed, by whom and specific routines)</td>
<td>□ Tub □ Shower □ Other:</td>
<td>□ AM □ PM</td>
</tr>
<tr>
<td>Grooming</td>
<td>□ Foot Care</td>
<td></td>
</tr>
<tr>
<td>Oral care</td>
<td>□ Mouth pain □ Inflamed gums/gingivitis/abscesses □ Broken/loose teeth</td>
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<tr>
<td>Dressing</td>
<td>Majority of day spent in: □ Street clothes □ Bed clothes</td>
<td></td>
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<tr>
<td>Devices used (describe regularity of use, assistance needed)</td>
<td>□ Glasses □ Contact Lenses □ Magnifying glass</td>
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<tr>
<td>Devices with resident</td>
<td>□ Family to bring □ to remain at home</td>
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<tr>
<td><strong>Elimination</strong></td>
<td></td>
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<tr>
<td>Difficulty with bowel care (describe)</td>
<td>□ Constipation □ Diarrhea □ Incontinence</td>
<td>□ Other:</td>
</tr>
<tr>
<td>Bowel Pattern: □ daily □ EOD □ q 3 days Bowel continence program:</td>
<td>□ Other:</td>
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<tr>
<td>Date of last BM:</td>
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<tr>
<td>Difficulty with bladder care (describe)</td>
<td>□ Frequency (how often) □ Indwelling catheter: (size/type)</td>
<td></td>
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<tr>
<td>□ Nocturia (n of times up) □ Incontinence □ Freq. of change: q</td>
<td>□ Aids: □ Pads</td>
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<tr>
<td>Toileting regime: Date of last change:</td>
<td>□ Liners □ Briefs/Pull-ups</td>
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<tr>
<td>□ Intermittent catheter q</td>
<td>□ Other:</td>
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<tr>
<td><strong>Nutrition</strong></td>
<td></td>
<td></td>
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<tr>
<td>Specific diet (specify)</td>
<td>□ Regular □ Soft □ Minced □ Pureed □ Diabetic □ Tube Feed (attach order)</td>
<td></td>
</tr>
<tr>
<td>□ Between meal snacks □ Other:</td>
<td>□ Regular fluids □ Nectar thick fluids □ Nutritional supplement: (type &amp; amount)</td>
<td></td>
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<tr>
<td>Malnutrition screening</td>
<td>Have you lost weight in the past 6 months without trying to lose this weight? □ Yes □ No</td>
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<tr>
<td>Have you been eating less than usual for more than a week? □ Yes □ No</td>
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<tr>
<td>Meal Time Assistance required (describe)</td>
<td>□ Independent □ Minimal assistance □ Dependent</td>
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<tr>
<td>□ Special utensils or adaptive equipment needed?</td>
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<tr>
<td>Eating/drinking difficulty</td>
<td>□ Chewing □ swallowing □ history of choking □ other:</td>
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<tr>
<td>□ c/o the taste of food □ leaves 25% of meal uneaten □ repetitive statements of hunger</td>
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<tr>
<td>□ food left in mouth □ dehydrated</td>
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<tr>
<td>Do you drink □ more □ less than 1 ½ litres of fluid per day?</td>
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<td>Distinct food preferences (specify)</td>
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<td>Food intolerance (specify)</td>
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<tr>
<td>Physical limitations (describe and include tolerance level)</td>
<td>Dominant hand: □ Rt □ Lt</td>
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<tr>
<td>□ Bedridden most of time □ Able to move independently indoors</td>
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<tr>
<td>Transferring/lifting assistance required (describe)</td>
<td>□ Bedrails □ Transfer □ Mechanical lift □ Sask-a-pole</td>
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<tr>
<td>□ Other:</td>
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<tr>
<td>Turning/positioning required (describe program)</td>
<td></td>
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<tr>
<td>Assistive devices required (list and indicate owner)</td>
<td>□ Walker □ Wheelchair (describe) □ Raised toilet seat</td>
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<tr>
<td>□ Brace □ wheels self □ Prosthesis: (list)</td>
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<tr>
<td>□ Crutch □ wheeled by other □ Orthopedic: (list)</td>
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<tr>
<td>□ Cane □ Splints □ Other: (list)</td>
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**Key Contact:** Name
<table>
<thead>
<tr>
<th>Relationship</th>
<th>Ph #: H:</th>
<th>W:</th>
<th>C:</th>
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</table>

**Legal Substitute Health Care Decision Maker:**
| Name | □ Proxy □ Personal Guardian □ Nearest Relative |
| Copy of documents: □ Proxy □ Personal Guardian |
| Ph #: H: | W: | C: |

**Other contacts:** (name, relationship, phone #s) 1.
2.

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AALTC-021.9, May 2018
### Normal Findings

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<tr>
<th>CNS</th>
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<tbody>
<tr>
<td>Tremors</td>
<td>Pupils unequal</td>
<td>Seizure disorder</td>
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<tr>
<td>Dizziness</td>
<td>Speech slurred</td>
<td>Stroke</td>
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<tr>
<td>Vertigo</td>
<td>Paraplegia</td>
<td>TIA</td>
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<tr>
<td>Unsteadiness</td>
<td>Quadriplegia</td>
<td>Cerebral palsy</td>
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<tr>
<td>Disoriented</td>
<td>Hemiplegia</td>
<td>Parkinson's disease</td>
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<tr>
<td>Memory loss</td>
<td>Hemiparesis</td>
<td>Traumatic brain injury</td>
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<tr>
<td>Headache</td>
<td>Motor/Sensory loss</td>
<td>Other:</td>
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<td>Heart murmur</td>
<td>Arhythmias</td>
<td>CHF</td>
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<tr>
<td>Cyanosis</td>
<td>Tachycardia</td>
<td>Hypertension</td>
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<tr>
<td>Edema</td>
<td>Bradycardia</td>
<td>Hypotension</td>
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<td>Other:</td>
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<td>Anemia</td>
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<td>Blood disorder</td>
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<td>Chest pain</td>
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<tr>
<td></td>
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<td>Syncpe</td>
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<tr>
<td>Shallow</td>
<td>Wheezing</td>
<td>Asthma</td>
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<td>Rapid</td>
<td>Cough</td>
<td>Pneumonia</td>
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<tr>
<td>Slow</td>
<td>SOB</td>
<td>Bronchitis</td>
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<tr>
<td>Dyspnea</td>
<td>Other:</td>
<td>Emphysema</td>
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<td>Other:</td>
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<tr>
<td>Flatulence</td>
<td>Diarrhea</td>
<td>Bulimia</td>
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<tr>
<td>Distension</td>
<td>Nausea</td>
<td>Hiatus hernia</td>
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<tr>
<td>Lump</td>
<td>Emesis</td>
<td>Umbilical hernia</td>
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<tr>
<td>Obesity</td>
<td>Indigestion</td>
<td>Stomach pain</td>
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<tr>
<td>Asymmetry</td>
<td>Heartburn</td>
<td>Other pain</td>
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<tr>
<td>Other:</td>
<td>Constipation</td>
<td>Other:</td>
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<td>Other:</td>
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<th>Integ</th>
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<tbody>
<tr>
<td>Bruising</td>
<td>Rash</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Lesions</td>
<td>Pale</td>
<td>Skin problems</td>
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<tr>
<td>Abrasions</td>
<td>Flushed</td>
<td>Lesions</td>
</tr>
<tr>
<td>Ulcer</td>
<td>Jaundice</td>
<td>Other:</td>
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</table>
| Pruritus | Cyanosis | Other:
| Other: |  |  |

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<tr>
<th>MS</th>
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<tbody>
<tr>
<td>Swelling</td>
<td>Limited ROM</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Deformities</td>
<td>Spasms</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Weakness/Atrophy</td>
<td>Amputation(s)</td>
<td>Osteoporosis</td>
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<tr>
<td>Other:</td>
<td></td>
<td>Gout</td>
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<tr>
<td></td>
<td></td>
<td>Pathological fracture:</td>
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<tr>
<td></td>
<td></td>
<td>Hip fracture (last 6 months):</td>
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<tr>
<td></td>
<td></td>
<td>Other fracture (last 6 months):</td>
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<tr>
<td></td>
<td></td>
<td>Pain: Hip, Joint</td>
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</tbody>
</table>
|  |  | Other:

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<thead>
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<th>EENT</th>
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<tbody>
<tr>
<td>Deafness</td>
<td>Facial paralysis</td>
<td>Diabetic retinopathy</td>
</tr>
<tr>
<td>Hoarseness</td>
<td>Aphasia</td>
<td>Hearing problems</td>
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<tr>
<td>Blurred vision</td>
<td>Dysphasia</td>
<td>Macular degeneration</td>
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<tr>
<td>Nystagmus</td>
<td>Discharge</td>
<td>Sinusitis</td>
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<tr>
<td>Other:</td>
<td>Conjunctivitis</td>
<td>Glaucoma</td>
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<tr>
<td></td>
<td>Tracheostomy</td>
<td>Cataracts</td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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<tbody>
<tr>
<td>Exophthalmia</td>
<td>Polydipsia</td>
<td>Diabetes Mellitus Type 1</td>
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<tr>
<td>Enlarged tongue</td>
<td>Polyphagia</td>
<td>Diabetes Mellitus Type 2</td>
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<tr>
<td>Goiter</td>
<td>Polyuria</td>
<td>Other:</td>
</tr>
</tbody>
</table>

### History/Current Medical Conditions

- Seizure disorder
- Alzheimer's
- Stroke
- Other dementia
- TIA
- Multiple Sclerosis
- Cerebral palsy
- Migraine headaches
- Parkinson's disease
- Depression
- Traumatic brain injury
- Other:
- Pancreatic disease
- Diabetic Neuropathy
- Pacemaker
- Implantable cardioverter/defibrillator
- CHF
- Rheumatic fever
- Hypertension
- MI
- Hypotension
- Angina
- Anemia
- ASHD
- Blood disorder
- VTE
- Chest pain
- PVD
- Syncpe
- Cardiac dysrhythmia
- Other:
- TB
- Frequent URI
- COPD
- Bronchitis
- Other:
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## Initial Assessment and History – Long Term Care

**Observations and Measurements**

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<th>Examinations</th>
<th>Date</th>
<th>By who</th>
<th>Where</th>
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<tbody>
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**Exposure to:**

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</table>

Site-specific ARO screening tool completed (if completed, this section can be omitted)

**Treated for Antibiotic Resistant Organisms (ARO(s)):**

- ☐ No
- ☐ Not known
- ☐ Yes: (describe)
- ☐ VRE
- ☐ MRSA
- ☐ Other:

Date of last influenza immunization: Date of pneumococcal vaccine:

**Date of last hospitalization:**

<table>
<thead>
<tr>
<th>Where</th>
<th>Why</th>
</tr>
</thead>
</table>

Site-specific pressure ulcer risk assessment completed

Resident's description of present condition: including pain and fatigue

**History pertinent to this move-in:** medical, surgical, trauma

**Meds**

Presently taking medications: ☐ Yes ☐ No ☐ See Best Possible Medication History (BPMH)

Pharmacy of choice: (Name and Location)

IV/Parenteral therapy (describe)

**Txs and Pro**

Presently receiving any treatments(s) (describe, including discipline(s) providing care)

- ☐ O2
- ☐ Ostomy care
- ☐ Trach Care
- ☐ Ventilator
- ☐ ROM
- ☐ Skin/Wound care: (specify)
- ☐ Foot care: (specify)
- ☐ Other:
- ☐ Complementary therapies: (list)

**Assessment of resident/family understanding of move-in and related learning needs**

**Safety concerns** ☐ Universal S.A.F.E. Precautions

1. In the past year, have you ever had any fall, including a slip or trip, in which you lost your balance and landed on the floor, ground, or lower level? ☐ Yes ☐ No
   a. Has medical attention been sought due to a fall? ☐ Yes ☐ No
2. Does the patient have any identifying gait, balance, and/or mobility difficulties? ☐ Yes ☐ No
3. Using clinical judgement, is this patient at risk of falling based on presenting symptoms? ☐ Yes ☐ No
   (Consider certain factors such as evolving illness (e.g. emerging delirium, impaired mobility, or new medications being prescribed), unfamiliar surroundings, acquired knowledge, other observations and assessments. If ‘yes’ to any of the questions, a comprehensive Fall Risk Assessment (e.g. Morse, SCOTT) must be completed along with care plan interventions.) ☐ Facility-specific falls risk assessment completed

Prevention measures in place:

- ☐ Hip protectors
- ☐ Non-skid socks
- ☐ Wheelchair seatbelts
- ☐ Other:

History of wandering:

- ☐ Yes ☐ No ☐ Past month ☐ Other:

Use of restraints (describe):

- ☐ Physical
- ☐ Environmental
- ☐ Chemical

Other:

**Personal/home/work concerns**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Lives alone, in own home</td>
<td>☐ With spouse/family</td>
</tr>
<tr>
<td>☐ Attends Day Program</td>
<td>☐ Home Care</td>
</tr>
</tbody>
</table>

**Significant others for support:**

**Involvement of significant other(s):**

- ☐ Family activities
- ☐ Transportation
- ☐ Financial
- ☐ Daily animal companion/presence
- ☐ Other: (describe)

**Meaningful relationship concerns**

- ☐ No contact ☐ family/friends
- ☐ Daily contact ☐ family/friends
- ☐ Weekly contact ☐ family/friends
- ☐ Recent loss of close member of family/friend
- ☐ Other:

**Ethnic/Educational aspects that affect care**
**ASSESSMENT OF MENTAL, EMOTIONAL, BEHAVIOURAL AND PSYCHIATRIC STATUS**

<table>
<thead>
<tr>
<th>NORMAL FINDINGS</th>
<th>ABNORMAL SIGNS</th>
<th>HISTORY</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSYCHOLOGICAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Slumped posture</td>
<td>□ Mannerisms</td>
<td>□ Unkempt</td>
</tr>
<tr>
<td></td>
<td>□ Inappropriate dress</td>
<td>□ Tic</td>
<td>□ Gestures</td>
</tr>
<tr>
<td></td>
<td>□ Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behaviour</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Restlessness</td>
<td>□ Impulsive</td>
<td>□ Verbally abusive</td>
</tr>
<tr>
<td></td>
<td>□ Aggression</td>
<td>□ Intimidating</td>
<td>□ Physically abusive</td>
</tr>
<tr>
<td></td>
<td>□ Argumentative</td>
<td>□ Hyperactive</td>
<td>□ Socially inappropriate</td>
</tr>
<tr>
<td></td>
<td>□ Agitation</td>
<td>□ Lethargic</td>
<td>□ Disruptive</td>
</tr>
<tr>
<td></td>
<td>□ Repetitive movements</td>
<td>□ Passive</td>
<td>□ Resisting care</td>
</tr>
<tr>
<td></td>
<td>□ Other:</td>
<td>□ Others</td>
<td>□ Resisting care</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Mutism/No speech</td>
<td>□ Hesitancy</td>
<td>□ Word salad</td>
</tr>
<tr>
<td></td>
<td>□ Aphasia</td>
<td>□ Echolalia</td>
<td>□ Ruminations</td>
</tr>
<tr>
<td></td>
<td>□ Slurred speech</td>
<td>□ Incoherent</td>
<td>□ Perseveration</td>
</tr>
<tr>
<td></td>
<td>□ Loquaciousness</td>
<td>□ Neologisms</td>
<td>□ Confabulation</td>
</tr>
<tr>
<td></td>
<td>□ Loose associations</td>
<td>□ Flight of ideas</td>
<td>□ Tangential speech</td>
</tr>
<tr>
<td></td>
<td>□ Other:</td>
<td>□ Repetitive vocalizations</td>
<td></td>
</tr>
<tr>
<td><strong>Thought Process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Confusion</td>
<td>□ Delusional</td>
<td>□ Suspicious</td>
</tr>
<tr>
<td></td>
<td>□ Hallucinations</td>
<td>□ Obsessional throughout day</td>
<td>□ Slow associations</td>
</tr>
<tr>
<td></td>
<td>□ Mental function variable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emotional State</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Flat affect</td>
<td>□ Depressed</td>
<td>□ Pervasive elation</td>
</tr>
<tr>
<td></td>
<td>□ Anxious</td>
<td>□ Grandiosity</td>
<td>□ Euphoric</td>
</tr>
<tr>
<td></td>
<td>□ Other:</td>
<td>□ Labile</td>
<td></td>
</tr>
<tr>
<td><strong>Orientation Concentration Alertness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Lack of judgement</td>
<td>□ ↓ LOC</td>
<td>□ Disoriented to:</td>
</tr>
<tr>
<td></td>
<td>□ Short term memory loss</td>
<td>□ Easily distracted</td>
<td>□ Person</td>
</tr>
<tr>
<td></td>
<td>□ Long term memory loss</td>
<td>□ No insight</td>
<td>□ Place</td>
</tr>
</tbody>
</table>

**See Notes**

**Appointments scheduled prior to this move-in:**

- **Funeral Home Chosen** (name, location)

**Orientation to unit**

<table>
<thead>
<tr>
<th>Belongings</th>
<th>Site-specific resident belongings form (if completed, then this section can be omitted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Physical Layout**

<table>
<thead>
<tr>
<th>Clothing</th>
<th>At bedside</th>
<th>Locked up</th>
<th>Labeled</th>
<th>Sent home</th>
<th>Other:</th>
</tr>
</thead>
</table>

**Daily Routine**

<table>
<thead>
<tr>
<th>Furniture</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ID**

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