




PRE-SCREENING ASSESSMENT MOCK-UP ver 14.0

Name
Date of Birth
PHN

Date
Date Approved
Approved By

Legend:  Bold italicized text displays on the Pre-Screen printout  MDS Question  Displays on the Care Guide printout

MOVING IN PROFILE


  1 Neighbourhood:

 2 ADMITTED FROM (AT ENTRY):

- ☐ Ambulatory Health Service
- ☐ Inpatient Acute Care Service
- ☐ Inpatient Rehabilitation Service (General)
- ☐ Inpatient Continuing Care Service
- ☐ Residential Care Service (24-hour nursing care)
- ☐ Inpatient Psychiatry Service
- ☐ Other / Unclassified Service
- ☐ Inpatient Rehabilitation Service (Specialized)
- ☐ Home Care Service
- ☐ Residential Care Service (board and care)
- ☐ Private Home (no home care)

 3 Facility name admitted from:

 4 Specify sending facility unit and phone #:


 5 Follow-up appointments from sending facility:

Department:
Date:
Time:
Location:
Phone Number:

Department:
Date:
Time:
Location:
Phone Number:

 6 Resident's preferred facility ☐ Yes ☐ No

If no, specify:

 7 LIVED ALONE (prior to entry): Enter 0 = No, 1 = Yes, 9 = Unknown.

 8 DNAR

- ☐ ***Attempt resuscitation (CPR)***
- ☐ ***Do not attempt resuscitation (DNAR; No CPR)***
- ☐ ***Unknown***

If Do not attempt resuscitation (DNAR; No CPR) checked above,




 Options for Care:

- ☐ ***1***
- ☐ ***2***
- ☐ ***3***
- ☐ ***4***
- ☐ ***Unknown*** If unknown, specify:

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COGNITIVE STATUS

9 COMATOSE - Persistent vegetative state or no discernible consciousness ☐ Yes ☐ No

10 COGNITIVE SKILLS FOR DAILY DECISION MAKING - Made decisions regarding tasks of daily life.

-  ☐ **INDEPENDENT** - decisions consistent and reasonable
☐ **MODIFIED INDEPENDENCE** - some difficulty in new situations only
☐ **MODERATELY IMPAIRED** - decisions poor; cues or supervision required
☐ **SEVERELY IMPAIRED** - never/rarely made decisions



11 Mental status - Check all that apply.

- ☐ **Alert**
☐ **Confused at times**
☐ **Always confused**
☐ **Depressed**
☐ **Oriented, person, place, time**
☐ **Acute delirium**
☐ (None of the Above)


COMMUNICATION

HEARING



12 HEARING (With hearing appliance, if used):


-  ☐ **HEARS ADEQUATELY** - normal talk, TV, phone
 ☐ **MINIMAL DIFFICULTY** - when not in quiet setting
☐ **HEARS IN SPECIAL SITUATIONS ONLY** - speaker has to adjust tonal quality and speak distinctly
☐ **HIGHLY IMPAIRED** (absence of useful hearing)

13 If hearing impaired, indicate:

-  ☐ **Impaired right ear**
☐ **Impaired left ear**
☐ **Impaired both ears**
☐ Not applicable

14 COMMUNICATION DEVICES/TECHNIQUES - Check all that apply last 7 days.




-  ☐ **Hearing aid, present & used**
 ☐ **Hearing aid, present & not used regularly**
☐ Other receptive communication techniques used (e.g. lip reading)
☐ (None of the Above)

 Specify other hearing specifics:

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COMMUNICATION

15 MODES OF EXPRESSION - Check all used by resident to make needs known.

- ☒ Speech
- ☐ Writing messages to express or clarify needs
- ☐ American sign language or Braille
- ☐ Signs, gestures, or sounds
- ☐ Communication board
- ☐ Other
- ☐ (None of the Above)

If other, specify:

16 Language(s) spoken: ☐ **English** ☐ **Cantonese** ☐ **Mandarin** ☐ **Punjabi** ☐ Other

 If other, specify:

Speaks...

17 Language(s) understood: ☐ **English** ☐ **Cantonese** ☐ **Mandarin** ☐ **Punjabi** ☐ Other

 If other, specify:

Understands...

18 MAKING SELF UNDERSTOOD (Expressing information content - however able):

- ☒ Understood
- ☒ Usually understood - difficulty finding words or finishing thoughts
- ☐ Sometimes understood - ability is limited to making concrete requests
- ☐ Rarely or never understood

makes self understood

usually makes self understood

sometimes makes self understood

rarely or never understood

19 SPEECH CLARITY (Code for speech in last 7 days):

- ☒ CLEAR SPEECH - distinct, intelligible words
- ☒ UNCLEAR SPEECH - slurred, mumbled words
- ☐ NO SPEECH - absence of spoken words

speech clear

speech unclear

no speech

20 ABILITY TO UNDERSTAND OTHERS (Understanding verbal information content - however able):




- ☒ Understands
- ☒ **Usually understands** - may miss some part or intent of message
- ☐ **Sometimes understands** - responds adequately to simple, direct communication
- ☐ **Rarely or never understands**

understands others

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VISION

21 VISION (Ability to see in adequate light/ with glasses if used)

- ☐ ADEQUATE - sees fine details including regular print in newspapers/books
- ☐ IMPAIRED - sees large print, but not regular print in newspaper/books
- ☐ MODERATELY IMPAIRED - limited vision; not able to see newspaper headlines, but can identify objects
- ☐ HIGHLY IMPAIRED - object identification in question, but eyes appear to follow objects
- ☐ SEVERELY IMPAIRED - no vision or sees only light, color, shapes; eyes do not appear to follow objects

sees regular print

sees large print

can identify objects only

appears to follow objects only

no vision

22 If visually impaired, indicate:

- ☐ *Impaired right eye*
- ☐ *Impaired left eye*
- ☐ *Impaired both eyes*
- ☐ *Prosthesis right eye*
- ☐ *Prosthesis left eye*
- ☐ *Prosthesis both eyes*
- ☐ Not applicable

23 VISUAL APPLIANCES - Glasses; contact lens; magnifying glass: ☐ Yes ☐ No

Comments:

24 Glasses: ☐ *glasses for reading only* ☐ *always wears glasses* ☐ *(None of the Above)*

BEHAVIOUR

25 Behaviour - Check all that apply.

- ☐ *No issues*
- ☐ *Can be physically aggressive*
- ☐ *Can be verbally aggressive*
- ☐ *Often agitated*
- ☐ *Socially inappropriate*
- ☐ *Refuses/ resists care*
- ☐ Other

Complete Describe what triggers the behaviour




If other, specify:

Describe what triggers the behaviour:

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26 BEHAVIOURAL SYMPTOMS - Code for behaviour in LAST 7 DAYS.

26a WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)

Behavioural symptom alterability in last 7 days:

- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily

26b Behavioural symptom alterability in last 7 days:

- ☐ Behaviour not present - OR - behaviour was easily altered
- ☐ Behaviour was not easily altered

26c Wandering - Check all that apply:

- ☐ ***One to one if off unit***
- ☐ ***Resident has a wandering alert system***
- ☐ (None of the Above)

Wandering description/comments:

27a VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS (others were threatened, screamed at, cursed at)

Behavioural symptom frequency in last 7 days:

- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily

27b Behavioural symptom alterability in last 7 days:

- ☐ Behaviour not present - OR - behaviour was easily altered
- ☐ Behaviour was not easily altered

28a PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)\

Behavioural symptom frequency in last 7 days:

- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily




28b Behavioural symptom alterability in last 7 days:

- ☐ Behaviour not present - OR - behaviour was easily altered
- ☐ Behaviour was not easily altered

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29a SOCIALLY INAPPROPRIATE OR DISRUPTIVE BEHAVIOURAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self abusive acts, sexual behaviour or disrobing in public, smeared or threw food or feces, hoarding, rummaged in others' belongings)

Behavioural symptom frequency in last 7 days:

- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily

29b Behavioural symptom alterability in last 7 days:

- ☐ Behaviour not present - OR - behaviour was easily altered
- ☐ Behaviour was not easily altered

30a RESISTS CARE (resisted taking meds or injections, ADL assistance, or eating)

Behavioural symptom frequency in last 7 days:

- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily

30b Behavioural symptom alterability in last 7 days:

- ☐ Behaviour not present - OR - behaviour was easily altered
- ☐ Behaviour was not easily altered

31 Behaviour plan:

32 Is a psychiatric consult anticipated? ☐ Yes ☐ No

If yes, specify:

SOCIAL WELL-BEING

33 UNSETTLED RELATIONSHIPS - Check all that apply.

- ☐ Covert/open **conflict with** or repeated criticism of **staff**
- ☐ **Unhappy with roommate**
- ☐ **Unhappy with residents other than roommate**
- ☐ Openly expresses **conflict/anger with family/friends**
- ☐ **Absence of** personal **contact with family or friends**
- ☐ **Recent loss of** close **family member or friend**
- ☐ **Does not adjust easily to change in routines**
- ☐ (None of the Above)




Comments:


34 Psychosocial/Cultural History:


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 **35** Companion / Family Support
(incl. pets):

 **36** Religious Practices /
Beliefs:


 **37** What is important for you
to know about the resident?

ACTIVITIES OF DAILY LIVING


EATING

 **38a** EATING - How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition). Code for **self-performance** over all shifts during last 7 days - not incl. set-up:

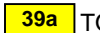
- ☐ Independent
- ☐ Supervision
- ☐ Limited assistance
- ☐ Extensive assistance
- ☐ Total dependence
- ☐ Activity did not occur during entire 7 days

 **38b** EATING - How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition). Code for **most support** provided over all shifts during last 7 days:

- ☐ No Setup or physical help from staff *independent*
- ☐ Setup help only *setup help only*
- ☐ One person physical assist *one person assist*
- ☐ Two + person physical assist *two+ person assist*
- ☐ ADL activity did not occur entire 7 days

 Specify any other eating/
drinking details related to swallowing:

TOILETING




 **39a** TOILET USE - How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes. Code for **self performance** over all shifts during last 7 days, not including setup.


- ☐ Independent
- ☐ Supervision
- ☐ Limited Assistance
- ☐ Extensive Assistance
- ☐ Total Dependence
- ☐ Activity did not occur during entire 7 days

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39b  **TOILET USE** - How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes. Code for most **support provided** over all shifts during last 7 days.


- ☐ No Setup or physical help from staff *independent*
- ☐ Setup help only *supervision*
- ☐ One person physical assist *one person assist*
- ☐ Two+ persons physical assist *two+ person assist*
- ☐ ADL activity did not occur entire 7 days

Toileting Comments:

HYGIENE

40a **PERSONAL HYGIENE** - How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing/drying face, hands, and perineum (EXCLUDE baths and showers). Code for **self performance** over all shifts during last 7 days, not including setup.

- ☐ Independent
- ☐ Supervision
- ☐ Limited assistance
- ☐ Extensive assistance
- ☐ Total dependence
- ☐ Activity did not occur during entire 7 days

40b  **PERSONAL HYGIENE** - How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing/drying face, hands, and perineum (EXCLUDE baths and showers). Code for most **support provided** over all shifts during last 7 days.

- ☐ No setup or physical help from staff *independent*
- ☐ Setup help only *setup help only*
- ☐ One person physical assist *one person assist*
- ☐ Two+ person physical assist *two+ person assist*
- ☐ ADL activity itself did not occur during entire 7 days

Hygiene Comments:

BATHING




41a **BATHING** - How resident takes full-body bath or shower, sponge bath, and transfers in and out of tub or shower (Exclude washing of back and hair). Code for most dependent in **self-performance**.

- ☐ Independent
- ☐ Supervision
- ☐ Physical help limited to transfer only
- ☐ Physical help in part of bathing activity
- ☐ Total dependence
- ☐ Bathing did not occur during entire 7 days

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41b BATHING - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (Exclude



 washing of back and hair). Code for **most support** provided over all shifts during last 7 days.

-  ☐ No setup or physical help from staff *independent*
- ☐ Setup help only *supervision*
- ☐ One person physical assist *one person assist*
- ☐ Two+ person physical assist *two+ person assist*
- ☐ ADL activity itself did not occur during entire 7 days


Bathing Comments:

MOBILITY / TRANSFER

42a TRANSFER - How resident moves between surfaces - to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet). Code for **self performance** over all shifts during last 7 days, not including setup.


-  ☐ *Independent*
-  ☐ Supervision *Stand by assist*
- ☐ Limited Assistance
- ☐ Extensive Assistance
- ☐ Total dependence
- ☐ Activity did not occur during entire 7 days


42b TRANSFER - How resident moves between surfaces - to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet). Code for **most support provided** over all shifts during last 7 days.

-  ☐ No Setup or physical help from staff
- ☐ Setup help only
- ☐ One person physical assist
- ☐ Two+ persons physical assist
- ☐ ADL activity did not occur entire 7 days



} Complete type of transfer
from bed to w/c

 Transfer Comments:

 Type of transfer from bed to wheelchair

-  ☐ One person minimal physical assist *one person minimal assist*
- ☐ *Sit to stand lift*
- ☐ *Mechanical total lift (floor based)*
- ☐ *Ceiling lift*

43 MODES OF TRANSFER (Check all that apply during last 7 days):




-  ☐ *Bedfast all or most of time*
- ☐ Bed rails used for bed mobility or transfer
- ☐ Lifted manually
- ☐ Lifted mechanically
-  ☐ *Transfer aid* (e.g. slide board, trapeze, cane, walker, brace)
- ☐ (None of the Above)

Specify:



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44 MODES OF LOCOMOTION - Check all that apply during last 7 days:

-  ☐ **Cane/walker/crutch**
-  ☐ Wheeled - self
- ☐ Other person wheeled
- ☐ Wheelchair **primary mode of locomotion**
- ☐ (None of the Above)
- } Complete type of w/c, ownership of w/c, ownership of cushion, w/c comments


 Walking

 Comments:

 Type of wheelchair:

-  ☐ **Powered Wheelchair**
- ☐ **Geri-Chair**
- ☐ **Tilt-in-space wheelchair**
- ☐ **Standard Manual Wheelchair**
- ☐ Other
- } How resident moves wheelchair:
- ☐ **Foot propel** ☐ **Hand propel**

If other, specify:


 Ownership of wheelchair ☐ Own ☐ Loan ☐ Other

If other, specify:

personal wheelchair

loaned wheelchair

wheelchair owned by ...


 Ownership of cushion ☐ Own ☐ Loan ☐ Other


If other, specify:

personal cushion

loaned cushion


cushion owned by...

 Wheelchair


 Comments:

CONTINENCE

45 BLADDER CONTINENCE - Code for resident's performance over all shifts. Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if employed:

-  ☐ **Continent** - Complete control
- ☐ **Usually continent** - incontinent episodes once a week or less
- ☐ **Occasionally incontinent** - 2+ times a week but not daily
- ☐ **Frequently incontinent** - tended to be incontinent daily but some control present
- ☐ **Incontinent** - Had inadequate control. Multiple daily episodes




46 BOWEL CONTINENCE - Control of bowel movement, with appliance or bowel continence programs, if used. Code for resident's performance over all shifts during last 14 days:

-  ☐ **Continent** - Complete control
- ☐ **Usually continent** - incontinent episodes less than weekly
- ☐ **Occasionally incontinent** - once a week
- ☐ **Frequently incontinent** 2-3 times a week
- ☐ **Incontinent** - had inadequate control all (or almost all) of the time







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47 APPLIANCES AND PROGRAMS - Check all that apply in last 14 days:

-  ☐ Any ***scheduled toileting plan***
-  ☐ ***Bladder retraining program***
-  ☐ External (***condom***) ***catheter***
-  ☐ ***Indwelling catheter*** Complete Indwelling Catheter information
- ☐ ***Intermittent catheter***
- ☐ ***Does not use toilet*** room/commode/urinal
- ☐ ***Pads/briefs used***
- ☐ Enemas/irrigation
-  ☐ ***Ostomy present***
- ☐ (None of the Above)
-  Specify appliances and programs if applicable (e.g. toileting plan):

 ***Insertion date of indwelling catheter:*** _____

Type: _____

Size: _____

Reason for insertion: _____

PAST MEDICAL HISTORY

48 Past Medical History

Diseases:

49 Pacemaker ☐ Yes ☐ No

If yes, Next Appointment Date:

Location:




CURRENT MEDICAL HISTORY

50 Recent Health Events:

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51 Current Medical History - Check only diseases that have a relationship to current ADL status, cognitive status, mood and behaviour status, medical treatments, nurse monitoring, or risk of death.

DISEASES

51a HEART/CIRCULATION

- ☐ **Arteriosclerotic heart disease** (ASHD)
- ☐ **Cardiac dysrhythmia**
- ☐ **Congestive heart failure**
- ☐ **Deep vein thrombosis**
- ☐ **Hypertension**
- ☐ **Hypotension**
- ☐ **Peripheral vascular disease**
- ☐ **Other cardiovascular disease**

51b NEUROLOGICAL

- ☐ **Amyotrophic lateral sclerosis (ALS)**
- ☐ **Alzheimer's disease**
- ☐ **Aphasia**
- ☐ **Cerebral palsy**
- ☐ **Cerebrovascular accident (stroke)**
- ☐ **Dementia other than Alzheimer's disease**
- ☐ **Hemiplegia/hemiparesis**
- ☐ **Huntington's chorea**
- ☐ **Multiple sclerosis**
- ☐ **Paraplegia**
- ☐ **Parkinson's disease**
- ☐ **Quadriplegia**
- ☐ **Seizure disorder**
- ☐ **Transient ischemic attack (TIA)**
- ☐ **Traumatic brain injury**

51c MUSCULOSKELETAL

- ☐ **Arthritis**
- ☐ **Hip fracture**
- ☐ **Missing limb** (e.g. amputation)
- ☐ **Osteoporosis**
- ☐ **Pathological bone fracture**

51d SENSORY

- ☐ **Cataracts**
- ☐ **Diabetic retinopathy**
- ☐ **Glaucoma**
- ☐ **Macular degeneration**

51e PSYCHIATRIC/MOOD

- ☐ **Anxiety disorder**
- ☐ **Depression**
- ☐ **Manic depressive** (bipolar disease)
- ☐ **Schizophrenia**

51f ENDOCRINE/METABOLIC/NUTRITIONAL

- ☐ Diabetes mellitus ☐ **Type 1** ☐ **Type 2**
- ☐ **Hyperthyroidism**
- ☐ **Hypothyroidism**

51g PULMONARY

- ☐ **Asthma**
- ☐ **Emphysema/COPD**

51h OTHER

- ☐ Allergies Specify drug
- ☐ **Anemia** & food allergies:
- ☐ **Cancer**
- ☐ **Gastrointestinal disease**
- ☐ **Liver disease**
- ☐ **Renal failure**
- ☐ (None of the Above)

Specify any other diseases:

52 INFECTIONS

- ☐ Antibiotic resistant infection (e.g. Methicillin resistant staph) → **MRSA** ☐ Yes ☐ No
- ☐ **VRE** ☐ Yes ☐ No

- ☐ **Cellulitis** → **Date of dx:**
- ☐ **Clostridium difficile** → **Date of last stool sample:**
- ☐ **Conjunctivitis**
- ☐ **HIV infection**
- ☐ **Pneumonia**




If other, specify:

- ☐ **Respiratory infection**
- ☐ **Septicemia**
- ☐ **Sexually transmitted diseases**
- ☐ **Tuberculosis (active)**
- ☐ **Urinary tract infection in LAST 30 DAYS**
- ☐ **Viral hepatitis**
- ☐ **Wound infection**
- ☐ (None of the Above)

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| | | | | | | |
|-----------|------------------------------------------|---------------------------|--------------------------|-------------------------------|------------|----------------------|
| 53 | <i>Pneumococcal vaccine</i> | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | Date Given | <input type="text"/> |
| 54 | <i>Diphtheria-Tetanus vaccine</i> | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | Date Given | <input type="text"/> |
| 55 | <i>Influenza vaccine</i> | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown | Date Given | <input type="text"/> |
| 56 | <i>TB screening required</i> | <input type="radio"/> Yes | <input type="radio"/> No | Date of chest x-ray: | | <input type="text"/> |
| | | | | Results of chest x-ray: | | <input type="text"/> |

57 STABILITY OF CONDITIONS - Check all that apply:

- ☐ Conditions make cognitive, ADL, mood or behaviour patterns unstable - (fluctuating, precarious, etc)
- ☐ Acute flare-up of a recurrent or chronic problem
- ☐ End-stage disease; 6 months or less to live
- ☐ (None of the Above)

Details related to stability of conditions:

58 Is a palliative consult anticipated? ☐ Yes ☐ No

If yes, specify:

59 PROBLEM CONDITIONS - Check all problems present in last 7 days unless other time frame is indicated:

Indicators of Fluid Status

- ☐ ***Weight gain or loss of 1.5 or more kg within a 7-day period***
- ☐ ***Inability to lie flat due to shortness of breath***
- ☐ ***Dehydrated***; Output exceeds Intake
- ☐ ***Insufficient fluid***; did NOT consume all/almost all liquids provided during last 3 days

Other

- ☐ ***Delusions***
- ☐ ***Dizziness/Vertigo***
- ☐ ***Edema***
- ☐ ***Fever***
- ☐ ***Hallucinations***
- ☐ ***Internal Bleeding***
- ☐ ***Recurrent lung aspirations in last 90 days***
- ☐ ***Shortness of breath***
- ☐ ***Syncope*** (fainting)
- ☐ ***Unsteady gait***
- ☐ ***Vomiting***
- ☐ (None of the Above)

Specify:

PAIN




60 PAIN SYMPTOMS: Code the highest frequency with which resident complains or shows evidence of pain in the last 7 days.


- ☐ ***No Pain***
- ☐ ***Pain less than daily***
- ☐ ***Pain daily***
- } Complete Intensity of Pain
and Pain Site


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 Intensity of pain in the last 7 days:


-  ☐ ***Mild pain***
☐ ***Moderate pain***
☐ ***Times when pain is horrible or excruciating***


 PAIN SITE: If pain present, check all sites that apply in the last 7 days.


-  ☐ ***Back pain***
 ☐ ***Bone pain***
☐ ***Chest pain*** while doing usual activities
☐ ***Headache***
☐ ***Hip pain***
☐ ***Incisional pain***
☐ ***Joint pain*** (other than hip)
☐ ***Soft tissue pain*** (e.g. lesion, muscle)
☐ ***Stomach pain***
☐ Other If other, specify:


 **61**  How does the resident prefer to manage pain
(incl. non-medical techniques)?

SAFETY/FALLS

 **62** ACCIDENTS - Check all that apply:

-  ☐ ***Fell in past 30 days***
☐ ***Fell in past 31-180 days***
☐ ***Hip fracture in last 180 days***
☐ ***Other fracture in last 180 days***
☐ (None of the Above)




 Specify number of falls:

 Specify number of fractures:

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63 Interventions for falls - Check all that apply. Complete Physical Restraint Protocol if restraints used.

- ☐ **Wheelchair Tilted**
- ☐ **Seat belt** Seat belt Type: ☐ **Front fastening** ☐ **Pen release** ☐ **Other** If other, specify:
- ☐ **Wheelchair with full lap tray**
- ☐ **Low bed**
- ☐ **Bed rail(s)** Up: ☐ **Top left** ☐ **Top right** ☐ **Bottom left** ☐ **Bottom right**
- ☐ **Bed Alarm**
- ☐ **Wheelchair Alarm**
- ☐ **Hip Protector** Specify:
- ☐ **Fall Mat** When: ☐ **Day** ☐ **Night** ☐ **Both**
Side: ☐ **Left side** ☐ **Right side** ☐ **Both sides**
- ☐ **Special toilet plan**
- ☐ Other Specify any other interventions:
- ☐ (None of the Above)

64 Specify other safety needs:

NUTRITION

65a HEIGHT (cm) (Record height in centimetres)

65b WEIGHT (kg) (Record weight in kilograms)

Base weight on most recent measure in LAST 30 DAYS; measure weight consistently in accord with standard facility practice (e.g. in AM after voiding, before meal, with shoes off, and in nightclothes).

66 Is the resident on a mechanically altered diet? ☐ **Yes** ☐ **No**

If no is checked,

Is the resident 70+ years with a history of: COPD, head/neck surgery or a neurological diagnosis? ☐ **Yes** ☐ **No**

If yes, print Dysphagia Screen for RN to complete.

67 ORAL PROBLEMS - Check all that apply:

- ☐ Chewing problem
- ☐ Swallowing problem
- ☐ Mouth pain
- ☐ (None of the Above)




68 NUTRITIONAL APPROACHES - Check all that apply in last 7 days.


- ☐ Parenteral / IV
- ☐ Feeding tube Complete feeding tube information
- ☐ Mechanically Altered Diet
- ☐ Syringe (oral feeding)
- ☐ Therapeutic diet
- ☐ Dietary supplement between meals
- ☐ Plate guard, stabilized built-up utensil, etc.
- ☐ On a planned weight change program
- ☐ None of the Above

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 **Feeding tube insertion date:**

Type of tube:


Feeding schedule:


Operative report available: ☐ Yes ☐ No

 **69** Diet Type - Check all that apply:


-  ☐ **Dysphagia**
- ☐ **NPO**
- ☐ **Diabetic**
- ☐ **Low potassium**
- ☐ **Low salt**
- ☐ **Tube feed**
- ☐ **Other**
- ☐ (None of the Above)

If other, specify:

 **70** Diet Texture - Check all that apply:


-  ☐ **Regular**
- ☐ **Cut-up**
- ☐ **Dental Soft**
- ☐ **Minced**
- ☐ **Pureed**
- ☐ **Other**
- ☐ (None of the Above)


If other, specify:

 **71** Fluid Consistency - Check all that apply:

-  ☐ **Thick fluids**
- ☐ **Thin fluids**

Eating comments:




 **72** Teeth/Dentures - Check all that apply:

-  ☐ **Own teeth**
 - ☐ **Dentures - upper**
 - ☐ **Dentures - lower**
 - ☐ **Partial Dentures - upper**
 - ☐ **Partial Dentures - lower**
- } **Wears**
- | | |
|---------------------------|--------------------------|
| <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="radio"/> Yes | <input type="radio"/> No |

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SKIN CONDITION

- 73** ULCERS due to any cause (record the number of ulcers at each ulcer stage-regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during the last 7 days. Code 9 = 9 or more (REQUIRES FULL BODY EXAM).
- 73a** Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when the pressure is relieved. 0 1 2 3 4 5 6 7 8 9
- 73b** Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. 0 1 2 3 4 5 6 7 8 9
- 73c** Stage 3: A full thickness of skin is lost, exposing subcutaneous tissues-presenting as a deep crater with or without undermining adjacent tissue. 0 1 2 3 4 5 6 7
- 73d** Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. 0 1 2 3 4 5 6 7

74 OTHER SKIN PROBLEMS OR LESIONS PRESENT - Check all that apply during last 7 days:

- ☐ **Abrasions, bruises**
- ☐ **Burns** (second or third degree burns)
- ☐ **Open lesions** other than ulcers, rashes, cuts (e.g. cancer lesions)
- ☐ **Rashes** - e.g. intertrigo, eczema, drug/heat rash, herpes zoster
- ☐ **Skin desensitized to pain or pressure**
- ☐ **Skin tears or cuts** (other than surgery)
- ☐ Surgical wounds
- ☐ (None of the Above)

75 HISTORY OF RESOLVED PRESSURE ULCERS

☐ Resident had a pressure ulcer that was resolved or cured in the last 90 days: ☐ Yes ☐ No

If yes, specify date resolved:

76 Location of skin problems:

77 SKIN TREATMENTS - Check all that apply during last 7 days:




- ☐ Pressure relieving device(s) for chair Describe:
- ☐ Pressure relieving device(s) for bed Describe:
- ☐ Turning/repositioning program
- ☐ Nutrition or hydration intervention to manage skin problems
- ☐ Ulcer care
- ☐ Surgical wound care
- ☐ Application of dressings (with or without topical medications other than to feet) Describe:
- ☐ Application of ointments/medications (other than to feet) Describe:
- ☐ Other preventive or protective skin care (other than to feet) Describe:
- ☐ (None of the Above)

If other, specify:

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SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS

78 SPECIAL CARE - (Check treatments received in LAST 14 DAYS.)

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
|  <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation |
|  <input type="checkbox"/> Dialysis Complete Dialysis Schedule |  <input type="checkbox"/> Suctioning |
| <input type="checkbox"/> IV medication |  <input type="checkbox"/> Trach. Care |
| <input type="checkbox"/> Intake/output | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Monitoring acute medical condition | <input type="checkbox"/> Ventilator or respirator |
| <input type="checkbox"/> Ostomy care |  <input type="checkbox"/> NONE OF ABOVE |
|  <input type="checkbox"/> Oxygen therapy | |
|  Comments: | <input type="text"/> |

 Dialysis Schedule:

- ☐ **Sunday**
☐ **Monday**
☐ **Tuesday**
☐ **Wednesday**
☐ **Thursday**
☐ **Friday**
☐ **Saturday**

Specify time:



Specify location and transportation:

79 Substance abuse - Check all that apply:

-  ☐ Drug/Alcohol
☐ Smoking → [Print Smoking Screen for RN to complete.](#)

Comments:

80 SPECIAL CARE - (Check programs received in LAST 14 DAYS.)




-  ☐ **Alcohol or drug treatment program**
 ☐ **Alzheimer's or dementia special care unit**
☐ Hospice care
☐ Pediatric care
☐ Respite care
☐ Training in skills to required return to the community (e.g. taking medications, housework, shopping, transportation, ADLs)
☐ NONE OF ABOVE

Comments:

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81 INTERVENTION PROGRAMS FOR MOOD, BEHAVIOUR, COGNITIVE LOSS - Check all interventions or strategies used in the LAST 7 DAYS, no matter where received.

- ☐ Special behaviour symptom evaluation program
- ☐ Evaluation by a licensed mental health specialist in LAST 90 DAYS
- ☐ Group therapy
- ☐ Resident-specific deliberate changes in the environment to address mood or behaviour patterns (e.g. providing bureau in which to rummage)
- ☐ Reorientation (e.g. cueing)
- ☐ NONE OF ABOVE

SLEEP

82 ***Sleeps through the night:*** ☐ Yes ☐ No

If no, specify:

ADDITIONAL INFORMATION

83 MMSE Score: _____ Date: _____

84 CPS Score: _____ Date: _____

85 CHESS Score: _____ Date: _____

86 Resident status:

☐ ***Accepted***

☐ ***Declined***

Reason:

☐ ***Care needs too high***

☐ ***Resident preference changed***

☐ ***Deceased***

☐ ***Care home refused - medical***

☐ ***Care home refused - social/beh/MH***

☐ ***Care needs too low***

☐ ***Resident no longer interested***

☐ ***Care home refused - equipment***

☐ ***Care home refused - other***

☐ ***Care home refused - staffing***




If other, specify:

87 Any additional comments:

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AREAS OF CONCERN

88 Areas of Concern - Check all that apply:

- | | |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <input type="checkbox"/> <i>Activities</i> | <input type="checkbox"/> <i>Feeding Tubes</i> |
| <input type="checkbox"/> <i>ADL Functional/Rehabilitation Potential</i> | <input type="checkbox"/> <i>Mood State</i> |
| <input type="checkbox"/> <i>Behavioural Symptoms</i> | <input type="checkbox"/> <i>Nutritional Status</i> |
| <input type="checkbox"/> <i>Cognitive Loss/Dementia</i> | <input type="checkbox"/> <i>Pain</i> |
| <input type="checkbox"/> <i>Communication</i> | <input type="checkbox"/> <i>Physical Restraints</i> |
| <input type="checkbox"/> <i>Dehydration/Fluid Maintenance Status</i> | <input type="checkbox"/> <i>Pressure Ulcers</i> |
| <input type="checkbox"/> <i>Delirium</i> | <input type="checkbox"/> <i>Psychosocial Well-Being</i> |
| <input type="checkbox"/> <i>Dental Care</i> | <input type="checkbox"/> <i>Psychotropic Drug Use</i> |
| <input type="checkbox"/> <i>End of Life</i> | <input type="checkbox"/> <i>Urinary Incontinence and Indwelling Catheter</i> |
| <input type="checkbox"/> <i>Falls</i> | <input type="checkbox"/> <i>Visual Function</i> |

Specify additional details: