INITIAL PSYCHOSOCIAL EVALUATION AND SOCIAL HISTORY

I. RESIDENT RIGHTS

A. If able to understand, was Resident Rights information reviewed with the resident and a copy provided? ❑ Yes ❑ No

B. If the resident is incompetent/incapacitated, is a Guardian, Durable Power of Attorney, or Surrogate identified in the chart? ❑ Yes ❑ No

C. (a) If the resident has an Advance Directive, is the resident satisfied with the Advance Directive they have written? ❑ Yes ❑ No

(b) If no Advance Directive, was information provided to Resident? ❑ Yes ❑ No

D. Does the resident know how to obtain spending money? ❑ Yes ❑ No

E. Does the resident know where they can make a private telephone call? ❑ Yes ❑ No

F. Does the resident want to self-administer medication? ❑ Yes ❑ No

G. Can the resident accurately describe who they are to contact in the facility with a concern or if they feel they are being mistreated? ❑ Yes ❑ No

H. (a) Is the resident free from drug and/or alcohol abuse? ❑ Yes ❑ No

(b) Is the resident free from smoking/tobacco issues? ❑ Yes ❑ No

II. QUALITY OF LIFE

A. Does the resident have enough clothing? ❑ Yes ❑ No

B. Does the resident feel compatible with roommate? ❑ Yes ❑ No

C. Is the resident's room personalized and homelike? ❑ Yes ❑ No

D. Is the resident aware of the spiritual services offered in the facility and how to engage in them? ❑ Yes ❑ No

III. COGNITIVE

A. Can the resident follow simple instructions? (i.e. touch your nose with thumb) ❑ Yes ❑ No

B. Can the resident make serious medical decisions for self? ❑ Yes ❑ No

C. Does the resident have adequate safety awareness? ❑ Yes ❑ No

If No, Specify:_____

IV. MOOD AND BEHAVIOR

A. Has the resident been free from unplanned weight loss? ❑ Yes ❑ No

B. Does the resident have sleep pattern disturbances? ❑ Yes ❑ No

C. Has the resident been free from abuse? ❑ Yes ❑ No

D. Is the resident free from any ❑ adjustment ❑ mood ❑ behavior problem? ❑ Yes ❑ No

E. Does the resident have family/significant other that is involved, supportive, and coping well at this time? ❑ Yes ❑ No

F. If applicable, is the resident being followed by their psychiatrist or psychologist (counselor) to this placement? ❑ Yes ❑ No ❑ NA

G. Is there a history of MI/ID and/or mental health issues? ❑ Yes ❑ No

V. DISCHARGE

A. Will the resident be staying in the facility for more than 20 days? ❑ Yes ❑ No

B. Has the resident been given educational and community referral information? (home health care, shopping or transportation help, diabetes info, etc.) ❑ Yes ❑ No ❑ NA

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

INITIAL PSYCHOSOCIAL EVALUATION AND SOCIAL HISTORY

Describe the resident's answer to the following questions (Complete within 7 days of admission):

A. Is there a history of physical, emotional, financial or sexual abuse?

B. How important is it to you to choose what clothes to wear, take care of your personal belongings, and choose between a tub bath, shower, bed bath, or sponge bath?

C. Would you like to help us plan your care while you are here? Would you like to come to our care plan meetings or have us come to your room to talk to you about your care?

D. What role does your family and friends play in your life? (Family members, family hx and circumstances). How important is it to you to have your family or a close friend involved in discussions about your care?

E. Have you discussed your advance directives with your family? If so, what advance directives do you have? Does the facility have a copy of resident's advance directives?

F. Religious preference? What services best meet your needs (weekly service, weekly pastoral visits, bible study, communion, mass, tribal council, prayer, self-study, TV services)?

G. What spiritual services (not necessarily church-related) do you practice/not wish to practice?

H. What cultural or ethnic traditions, beliefs or practices are important to you?

I. Have you had any difficulty coping/adjusting to moving here? Why/Why not? How important is it to you to be able to use the phone in private, have a place to lock your things to keep them safe and choose your own bedtime? What other preferences are important to you?

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

INITIAL EVALUATION EVALUATION AND SOCIAL HISTORY

J. (a) Pre-admission living situations and reason for admission:

(b) What are your goals while living in this facility?

K. Do you understand what your illness/disease is? Have you had any difficulty coping/adjusting to your illness/disease? How is your spouse/family adjusting?

L. Who is involved in your current support system (friends, family, church, community)?

M. Relevant past history info/past roles (including education, marriage(s), occupation, retirement, registered voter, etc.)

N. Are there any unresolved issues from the past that you are still concerned about?

O. Hobbies/Interests/Talents:

P. Likes/Dislikes (people, situations, food, etc.). How important is it to you to have snacks available between meals? Choose your bedtime/awakening time? Go outside, weather permitting?

PROVIDE DESCRIPTION FROM YOUR OWN OBSERVATION

A. Describe the resident's cognitive status and communication abilities.

B. Describe the resident's personality traits and strengths at this time (e.g. shy, friendly, angry, pessimistic, strong willed, pensive, blank affect, strong spiritual beliefs, helpful) and before admission.

C. Describe the resident's ability to interact with others, social skills and social pattern.

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

INITIAL PSYCHOSOCIAL EVALUATION AND SOCIAL HISTORY

E. Describe any mood or behavior problem. Does the resident seem to be depressed and/or anxious? Has resident ever had mental health; psychological treatment in the past? (Include any previous or current meds.)

F. What are the resident's goals for discharge?

1. Does the resident/family view placement as long-term? Is there potential for the resident to live in a more independent setting (if no, why not)? Is the resident motivated to achieve independence goals?

2. What are the resident/family goals for improvement:

3. List any needs/learning that should be provided before or after the resident is discharged (if applicable).

Summary: Add any additional issues which have the potential to positively/negatively affect the resident's psychosocial well-being such as adjustment to the facility or would require social service intervention (i.e. weight loss, sleeplessness, restraint use, physical limitations, sensory limitations, pain management, hospice, losses, finances).

Signature/Title:_____ ***Date:***_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed