ACTIVITY EVALUATION

❍ Admission ❍ Readmission ❍ Quarterly ❍ Annual ❍ Significant Change ❍ Other_____

BACKGROUND/FACTUAL INFORMATION

DOB:_____ Birthplace:_____ Date of admission:_____

Living arrangements prior to admission: ❍ Home ❍ Assisted Living ❍ Another LTC facility ❍ Other:_____

Planning for discharge: ❍ No ❍ Yes, specify goal:_____

Marital status: ❍ M ❍ D ❍ W ❍ S Spouse/partner/significant other's name:_____

Primary language spoken:_____ Interpreter needed: ❍ No ❍ Yes Veteran: ❍ No ❍ Yes

Personal Preferences: Preferred name_____ Food_____

Enjoys animals: ❍ No ❍ Yes Alcohol use: ❍ No ❍ Yes Tobacco use: ❍ No ❍ Yes

Former occupation(s):_____ Highest level of education:_____

Clubs/Organizations:_____

Voting Interests: Registered voter: ❍ No ❍ Yes Interested in voting: ❍ No ❍ Yes, prefers: ❍ Absentee ❍ Going to polls

Spiritual Involvement: Church/religious preference and level of participation:_____

If currently a member of a church, was church notified of resident's admission? ❍ No ❍ Yes

If not, should the facility contact? ❍ No ❍ Yes, contact person and phone no._____

PREFERENCE INTERVIEWS

❑ Resident ❑ Family or Significant Other ❑ Staff

Show resident the response options and say: ***"While you are in this facility..."*** *Enter answer codes in boxes.*

Coding: 1. Very important 2. Somewhat important 3. Not very important 4. Not important at all 5. Important, but can't do or no choice 9. No response or non-responsive

Interview for Daily Preferences	Interview for Activity Preferences
A. *how important is it to you to* ***choose what clothes to wear?***	**A.** *how important is it to you to* ***have books, newspapers, and magazines to read?***
B. *how important is it to you to* ***take care of your personal belongings or things?***	**B.** *how important is it to you to* ***listen to music you like?***
C. *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***	**C.** *how important is it to you to* ***be around animals such as pets?***
D. *how important is it to you to* ***have snacks available between meals?***	**D.** *how important is it to you to* ***keep up with news?***
E. *how important is it to you to* ***choose your own bedtime?***	**E.** *how important is it to you to* ***do things with groups of people?***
F. *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***	**F.** *how important is it to you to* ***do your favorite activities?***
G. *how important is to you to* ***be able to use the phone in private?***	**G.** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
H. *how important is it to you to* ***have a place to lock your things to keep them safe?***	**H.** *how important is it to you to* ***participate in religious services or practices?***

ACTIVITY PURSUIT PATTERNS (P - Past interest; C - Current interest; N - No interest)

***Specify type of activity on resident's plan of care (example: Cards - Bridge)**

P C N	ACTIVITY	P C N	ACTIVITY	P C N	ACTIVITY
❑ ❑ ❍	Cards	❑ ❑ ❍	Spiritual/religious activities	❑ ❑ ❍	Golfing
❑ ❑ ❍	Games	❑ ❑ ❍	Trips/shopping	❑ ❑ ❍	Helping others/volunteer work
❑ ❑ ❍	Crafts/arts/hobbies	❑ ❑ ❍	Spending time outdoors	❑ ❑ ❍	Parties/social events
❑ ❑ ❍	Exercise/walking/jogging	❑ ❑ ❍	Walking/wheeling outdoors	❑ ❑ ❍	Keeping up with the news
❑ ❑ ❍	Sports	❑ ❑ ❍	Watching TV/radio	❑ ❑ ❍	Community outings
❑ ❑ ❍	Music	❑ ❑ ❍	Watching movies	❑ ❑ ❍	Groups/organizations
❑ ❑ ❍	Reading/audio books	❑ ❑ ❍	Gardening/plants	❑ ❑	Other:
❑ ❑ ❍	Writing	❑ ❑ ❍	Talking/conversing	❑ ❑	Other:
❑ ❑ ❍	Baking/cooking	❑ ❑ ❍	Woodshop/toolshop	❑ ❑	Other:
❑ ❑ ❍	Computer	❑ ❑ ❍	Hunting/fishing/trapping	❑ ❑	Other:

When would you prefer to participate in scheduled activities? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❍ None of these, explain:_____

Preferred activity setting(s): ❑ Own room ❑ Community/activities room ❑ Inside facility/off unit ❑ Outside facility ❑ Other, explain:_____

Do you take naps: ❍ No ❍ Yes, time of day and how long:_____

Would you like to have a service-related work/job assignment? ❍ No ❍ Yes, type:_____

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

❑ Continued on Reverse

ACTIVITY EVALUATION

ADDITIONAL PERTINENT INFORMATION

PHYSICAL STATUS

Diagnoses:_____

Therapies Ordered: (days/times scheduled):_____

Diet Order:_____ ❍ Feeds self ❍ Needs assist, specify:_____

❑ Needs adaptive equipment, specify:_____

Vision: ❍ Good ❍ Poor ❍ Blind ❑ Wears glasses ❑ Other visual adaptive needs:_____

Able to read: ❍ No ❍ Yes **Needs assist with reading:** ❍ No ❍ Yes, specify:_____

Hearing: ❍ Good ❍ Poor ❍ Deaf ❑ Uses hearing aid ❍ Refuses to wear hearing aid **Hears best in:** ❑ Rt ear ❑ Lt ear

Speech: ❍ Clear ❍ Unclear, explain:_____

Mobility: Ambulates ❍ Independently ❍ With assist ❑ 1 person ❑ 2 persons ❑ Cane ❑ Wheelchair ❑ Other:_____

❑ Gerichair ❑ Confined to bed ❑ Other:_____

❑ Needs adapted activity, specify:_____

❑ Needs assistance getting to and from activities, specify:_____

Arm Function: **Right:** ❍ Full ❍ Partial ❍ None **Left:** ❍ Full ❍ Partial ❍ None

Hand Function: **Right:** ❍ Full ❍ Partial ❍ None **Left:** ❍ Full ❍ Partial ❍ None

Able to write: ❍ No ❍ Yes **Needs assist with writing:** ❍ No ❍ Yes, specify:_____

COGNITIVE/COMMUNICATION

❑ Requires reminders/cues

❑ Requires extensive verbal cuing

❑ Cannot comprehend instructions

❑ Needs adapted activity, specify:_____

❑ Needs adaptive equipment, specify:_____

❑ Other, specify:_____

ATTITUDE (PSYCHOSOCIAL WELL-BEING)

Attitude: ❑ Enthusiastic ❑ Cooperative ❑ Cheerful ❑ Willing to try ❑ Motivated

❑ Depressed/sad ❑ Uncooperative ❑ Withdrawn ❑ Apathetic ❑ Dwells on illness/other problems

Attitude toward life and activities in general: ❍ Interested ❍ Disinterested

Attitude toward admission: ❍ Accepting ❍ Resistant/sad, explain:_____

SPECIAL PRECAUTIONS/LIMITATIONS/CONSIDERATIONS

❑ Diabetic	❑ Combative	❑ Alcohol limitations	❑ CVA	❑ Prone to seizure
❑ Limited liquids	❑ Verbally abusive	❑ No/limited cigarettes	❑ PTSD or trauma history	❑ Sun-sensitive meds
❑ Pureed or soft foods	❑ Sexually aggressive	❑ Smoking risk	❑ Pacemaker	❑ Wanders
❑ Choking risk	❑ Bleeding risk	❑ Assist w/ADLs	❑ Requires oxygen	❑ ID bracelet
❑ Restraints:_____		❑ Heart problems	❑ Other, specify:_____	
❑ Alarms used:_____		❑ DNR	_____	

Allergies: ❍ NKA ❑ Food:_____ ❑ Drug:_____ ❑ Other:_____

Additional comments:_____

SOURCE(S) OF INFORMATION (Other than Resident)

NAME	RELATIONSHIP	DATE

Signature/title of person completing this form:_____ Date:_____

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