



RN ASSESSMENT

[The MAS RN is responsible and accountable for the completion of a comprehensive assessment and evaluation of patients' nursing care needs ABN 610-x-7-.06(3)]

Initial Annual Status Change Other (State)

Person's Name				Case #/SS#	
Date	Facility Name				
DOB	Gender: (<input checked="" type="checkbox"/> One) <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Race	Date of Admission/ Readmission (circle one)	Time of Admission
					(<input checked="" type="checkbox"/> One) <input type="checkbox"/> AM <input type="checkbox"/> PM
Transported By: <input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Ambulance <input type="checkbox"/> Other _____		Received From:	Accompanied By:	Relationship	

MEDICAL HISTORY

Name of PCP/CRNP(s): (primary care provider)					
Phone #s:	()				()
Other Physicians:					
Date of Last PCP Visit:	Date of Last Physical Exam				
	Name of PCP performing exam				
Baseline Data	BMI	WT	HT	Waist Circumference	
Date of Last TB Skin Test or CXR	Result				
Vital Signs	T _____	P _____	R _____	BP _____	Arm: <input type="checkbox"/> R <input type="checkbox"/> L
Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Last Menstrual Period		<input type="checkbox"/> N/A
	Breast Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Changes in Libido <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Date of Last Mammogram		PSA Date _____ Results _____ <input type="checkbox"/> N/A		
	Results		Erectile/Ejaculatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Allergies	<input type="checkbox"/> None <input type="checkbox"/> EpiPen Required				
	<input type="checkbox"/> Medication(s) _____				
	<input type="checkbox"/> Food(s) _____				
	<input type="checkbox"/> Other (Seasonal? Symptoms?) _____				

Pain	<input type="checkbox"/> None
	Location(s) _____
	Frequency <input type="checkbox"/> Daily <input type="checkbox"/> Daily/Intermittent <input type="checkbox"/> Constant <input type="checkbox"/> Other
	Intensity _____ (state # on 10 scale) <input type="checkbox"/> Mild <input type="checkbox"/> Distressing <input type="checkbox"/> Severe <input type="checkbox"/> Unbearable
	<input type="checkbox"/> No <input type="checkbox"/> Yes (If yes explain)
Pain on Admission _____	

Special Treatments/Procedures/ Equipment (List all including purpose):	<input type="checkbox"/> None

Past Surgeries/Implants (list all including year and location):	<input type="checkbox"/> None

Past Psychiatric/Medical Hospitalizations (List all including year/location/reason):	<input type="checkbox"/> None

FAMILY / RELATIONSHIPS				<input type="checkbox"/> None
Marital Status	Children	Parents	Siblings	Significant Others
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other	<input type="checkbox"/> Yes Number: _____ <input type="checkbox"/> No	Mother <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Father <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	<input type="checkbox"/> None <input type="checkbox"/> Yes Number _____ # Alive _____ # Deceased _____	Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ Friend(s) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other

RELIGIOUS/SPIRITUAL/CULTURAL

Religious Affiliation	<input type="checkbox"/> None
Attend Church?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cultural/Ethnic Practices That Impact Care/Teaching (List)	<input type="checkbox"/> None

CURRENT STATUS

PHYSICAL LIMITATIONS (Muscle/Skeletal System)

<input type="checkbox"/> NONE	Site	Degree
Paralysis/paresis		
Contracture(s)		
Congenital Anomalies		
Prosthesis		
Other		

FUNCTIONAL ABILITY

AMBULATION	WEIGHT BEARING	TRANSFERS	SUPPORTIVE DEVICES
<input type="checkbox"/> Independent <input type="checkbox"/> 1 Person Assist <input type="checkbox"/> 2 Person Assist <input type="checkbox"/> With Device (<i>name</i>) _____ <input type="checkbox"/> WC only <input type="checkbox"/> WC Propels Self	<input type="checkbox"/> Full Weight <input type="checkbox"/> Partial Weight <input type="checkbox"/> Non-Weight Bearing	<input type="checkbox"/> Independent <input type="checkbox"/> 1 Person Assist <input type="checkbox"/> 2 Person Assist <input type="checkbox"/> Total Dependence	<input type="checkbox"/> Elastic Hose <input type="checkbox"/> Hand Rolls <input type="checkbox"/> Sheepskin <input type="checkbox"/> Other (<i>list</i>) _____ _____ _____

GENERAL SKIN CONDITION: (Check all that apply)

	SITE		SITE
<input type="checkbox"/> Dry		<input type="checkbox"/> Oily	
<input type="checkbox"/> Edematous		<input type="checkbox"/> Cyanotic	
<input type="checkbox"/> Pale		<input type="checkbox"/> Warm	
<input type="checkbox"/> Moist		<input type="checkbox"/> Cold	
<input type="checkbox"/> Reddened		<input type="checkbox"/> Jaundiced	
<input type="checkbox"/> Ashen		<input type="checkbox"/> Other	

Hearing		R	L	Vision		R	L	Speech	
<input type="checkbox"/> Adequate				<input type="checkbox"/> Adequate				<input type="checkbox"/> Clear	
<input type="checkbox"/> Poor				<input type="checkbox"/> Poor				<input type="checkbox"/> Aphasic	
<input type="checkbox"/> Deaf				<input type="checkbox"/> Blind				<input type="checkbox"/> Other	
<input type="checkbox"/> Hearing Aid				<input type="checkbox"/> Glasses/Contacts				Language:	

Oral	Eating/Nutrition	Sleep	Bathing/ Grooming	Indep	Assist	Dep
<input type="checkbox"/> Own Teeth <i>(Note condition)</i> DENTURES <input type="checkbox"/> Partial <input type="checkbox"/> Full <input type="checkbox"/> Upper <input type="checkbox"/> Lower Fit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Independent <input type="checkbox"/> Needs Assist <input type="checkbox"/> Dysphasic (reason) <hr/> <input type="checkbox"/> Adaptive Equipment <i>(type)</i> <hr/> <input type="checkbox"/> Diet (Consistency/limitations)	Usual Bedtime _____ Usual Arising Time _____ Nap <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency/Length	<input type="checkbox"/> Tub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> Bed Bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Oral Hygiene			<input type="checkbox"/>
Shave			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shampoo			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

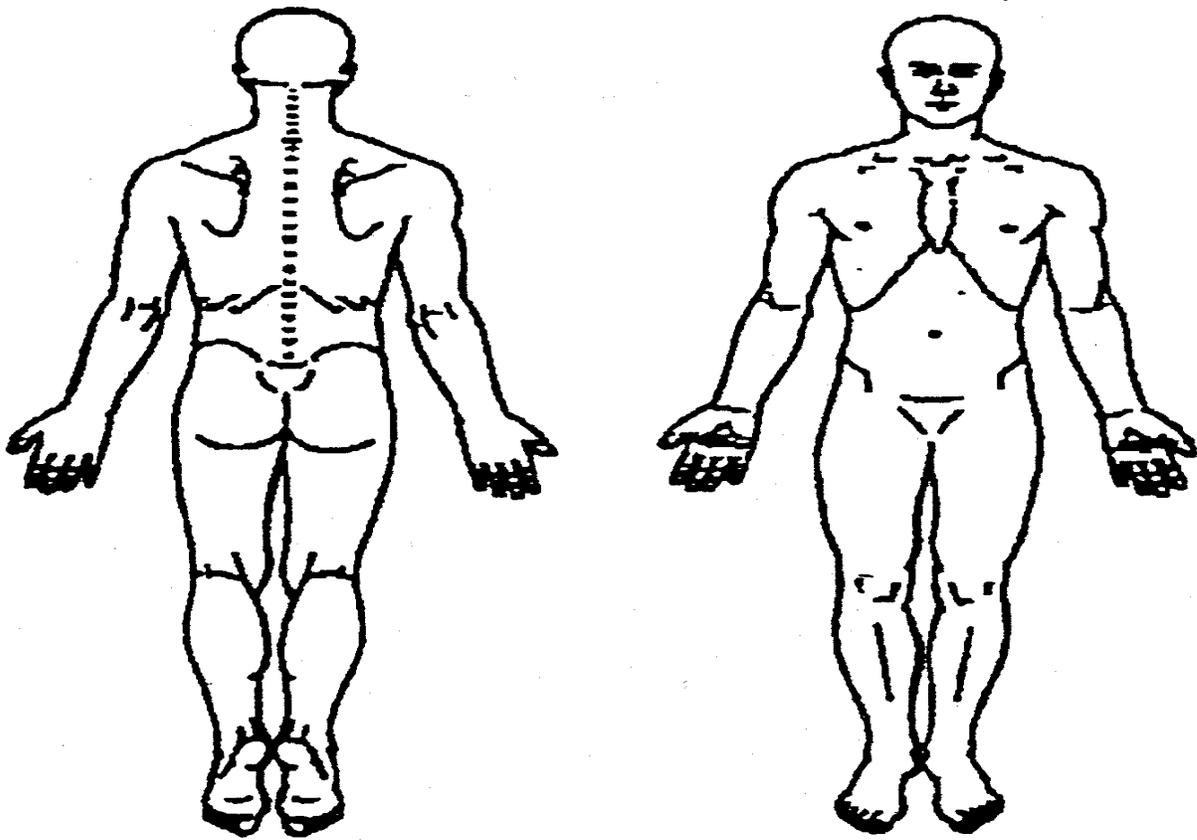
BOWEL AND BLADDER EVALUATION (GENTIAL/URINARY)

Bowel Continent		Bladder Continent		Frequent Constipation	
Other:		Other:			
<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
How managed?		How managed?		How managed?	

PERSONAL/FAMILY HISTORY

- Diabetes (Endocrine): No Self Family
 Today's Blood Sugar Results (if applicable) _____ Random Fasting
- Cardiovascular Disease: No Self Family
 Heart Attack Stroke Other _____
- High Cholesterol: No Self Family

PSYCHOSOCIAL FUNCTIONING			
Oriented	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Person <input type="checkbox"/> Situation	<input type="checkbox"/> Place <input type="checkbox"/> Facility
General Appearance	<input type="checkbox"/> Dressed/groomed appropriately for age/sex/situation <input type="checkbox"/> Disheveled <input type="checkbox"/> Pale <input type="checkbox"/> Emaciated <input type="checkbox"/> Sad <input type="checkbox"/> Happy		
Level of Consciousness/ Behavior	<input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Expressionless <input type="checkbox"/> Cooperative <input type="checkbox"/> Rigid/Tense <input type="checkbox"/> Other (<i>explain</i>)	<input type="checkbox"/> Responsive <input type="checkbox"/> Combative <input type="checkbox"/> Tics/Tremors <input type="checkbox"/> Hostile <input type="checkbox"/> Compulsive	<input type="checkbox"/> Hyperactive <input type="checkbox"/> Joyful <input type="checkbox"/> Pacing <input type="checkbox"/> Calm
Speech	<input type="checkbox"/> Talkative <input type="checkbox"/> Nonverbal <input type="checkbox"/> Loud <input type="checkbox"/> Other (<i>explain</i>)	<input type="checkbox"/> Forced <input type="checkbox"/> Slurred <input type="checkbox"/> Illogical	<input type="checkbox"/> Pressured/Excessive <input type="checkbox"/> Impediment <input type="checkbox"/> Monosyllabic
Affect/Mood	<input type="checkbox"/> Appropriate <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Friendly <input type="checkbox"/> Other (<i>explain</i>)	<input type="checkbox"/> Depressed <input type="checkbox"/> Guarded <input type="checkbox"/> Cooperative	<input type="checkbox"/> Elated <input type="checkbox"/> Flat <input type="checkbox"/> Uncooperative
Thoughts	<input type="checkbox"/> Normal <input type="checkbox"/> Wandering <input type="checkbox"/> Illusions <input type="checkbox"/> Homicidal <input type="checkbox"/> Other (<i>explain</i>)	<input type="checkbox"/> Guarded <input type="checkbox"/> Disorganized <input type="checkbox"/> Delusional <input type="checkbox"/> Suicidal	<input type="checkbox"/> Flighty <input type="checkbox"/> Paranoid <input type="checkbox"/> Hallucinations
Memory	<input type="checkbox"/> Remote Memory (past) <input type="checkbox"/> Recent Memory	<input type="checkbox"/> Delayed Recall (repeat after 5 minutes) <input type="checkbox"/> Attention Level (ability to concentrate)	
Insight	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <i>(What is causing your problem? What causes you to be here today?)</i>		
Judgment	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <i>(What would you do if you ran out of meds?)</i>		
Personal Habits	Smokes Cigarettes/Cigar/Pipe <input type="checkbox"/> Yes / <input type="checkbox"/> No Amt./day	Drinks Alcohol <input type="checkbox"/> Yes / <input type="checkbox"/> No Amt./day	Illegal Drug Use <input type="checkbox"/> Yes / <input type="checkbox"/> No Type/Freq
	Have you received assistance to stop smoking? <input type="checkbox"/> Yes / <input type="checkbox"/> No If yes, when/where?	Have you received treatment for alcohol? <input type="checkbox"/> Yes / <input type="checkbox"/> No If yes, when/where?	Have you received treatment for drug misuse/abuse? <input type="checkbox"/> Yes / <input type="checkbox"/> No If yes, when/where?
Family Support	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Family Relationship	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor



REVIEW OF SYSTEMS: (Skin, HEENT, Cardio, Respiratory, Gastrointestinal, Genitourinary, musculoskeletal, Psychosocial, Nervous, Blood)	
SKIN: <input type="checkbox"/> Warm <input type="checkbox"/> Dry <input type="checkbox"/> Intact	Color:
Comments:	
HEENT (Head, Eyes, Ears, Nose, Throat): <input type="checkbox"/> Symmetric <input type="checkbox"/> Pupils equal/reactive <input type="checkbox"/> No drainage/inflammation	
Comments:	
Cardiopulmonary: <input type="checkbox"/> Lung sounds clear <input type="checkbox"/> Heart beat regular <input type="checkbox"/> No edema <input type="checkbox"/> Pulses present (carotid, radial, pedal)	
Comments:	
GI: <input type="checkbox"/> Abd soft <input type="checkbox"/> Bowel sounds present X 4 quads <input type="checkbox"/> No distention <input type="checkbox"/> Hx of GERD	
Comments:	
GU: <input type="checkbox"/> "No pain/burning on urination" <input type="checkbox"/> "No lesions" <input type="checkbox"/> "No drainage" <input type="checkbox"/> Breast WNL (Last mammogram _____)	
Comments:	
Musculoskeletal: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Normal gait <input type="checkbox"/> Normal posture <input type="checkbox"/> No abnormal movements <input type="checkbox"/> Devices (list)	
Comments:	
Neuro/Psychosocial: <input type="checkbox"/> No hx of Seizures <input type="checkbox"/> A & O X3 <input type="checkbox"/> No maladaptive behaviors	
Comments:	
Blood: <input type="checkbox"/> No blood disorders <input type="checkbox"/> Lab work done within last 12 months <input type="checkbox"/> Lab WNL	
Comments:	
MAS RN SIGNATURE	DATE

