MAS 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**

Person's Name:					Case # or Last 4 SS#
Date:	Agency Name:				
DOB:	Gender: (✓ One) ☐ Male ☐ Female Pronoun________	Age:	Race:	Date of Admission:	Time of Admission: (if applicable) (✓ One) ☐ AM ☐ PM
Transported By: ☐ Car ☐ Van ☐ Ambulance ☐ Other ___________ (if applicable)		Received From: ☐ Home____________ ☐ Agency____________ Hospital___________ Other ____________		Accompanied By Name:____________ ________________ Contact #: ________________ ________________ ____	Relationship:

MEDICAL HISTORY

Name of PCP/CRNP(s):	(primary care provider)		
Date of Last PCP Visit:		**Date of Last Physical Exam**	
		Name of PCP performing exam	
Phone #s:	PCP ( )	CRNP ( )	
Other Physicians:	Name	Name	Name
	Type	Type	Type
	Contact #	Contact #	Contact #
	Name	Name	Name
	Type	Type	Type
	Contact #	Contact #	Contact #
Allergies	**Reaction** ☐ NKA ☐ Food(s)________________ ☐ Medication(s)________________ ☐ Environmental________________ ☐ Other(Seasonal?Symptoms?)________________ ________________		

Name:	Case # or Last 4 SS#
Baseline Data	**BMI** / **WT** **HT** / **Waist Circumference**
Vital Signs	T _____ P _____ R ____ BP _______ Arm: ☐ R ☐ L O2 SAT_____ FSBS ______ **(IF APPLICABLE)**
Pain	☐ None Pain on Admission ☐ Yes ☐ No (Explain)_____________________ ☐ Acute ☐ Chronic Location:____ Frequency: ☐ Daily ☐ Daily/Intermittent ☐ Constant ☐ Other________________ Intensity ☐ Mild ☐ Distressing ☐ Severe ☐ Unbearable
Immunizations	Flu__/__/____ Pneumonia __/__/____ Shingles __/__/____ Tetanus __/__/___ Covid __/__/___ TB Test __/__/____ Other:____________Date:_____________ Other:____________Date:__________ Other:____________Date:_____________

Special Treatments	**Special Procedures:**	**Special Equipment:**
☐ None	☐ None	☐ None
List:__________________	List:_______________________	List: _____________________

HX Surgeries/Implants ☐ None

Date: / / Location: Reason

Date: / / Location: Reason

Date: / / Location: Reason

HX Psychiatric/Medical Hospitalizations ☐ None

Date: / / Location: Reason

Date: / / Location: Reason

Date: / / Location: Reason

Name: Case # or Last 4 SS#

FAMILY / RELATIONSHIPS

Marital Status	Children	Parents	Siblings	Significant Others
☐ Married ☐ Single ☐ Divorced ☐ Other	☐ Yes Number: ____ ☐ Alive _____ ☐ Deceased ____ ☐ None	Mother ☐ Alive ☐ Deceased ☐ Unknown Father ☐ Alive ☐ Deceased ☐ Unknown ☐ Adopted	☐ Yes Number _____ ☐ Alive _____ ☐ Deceased _____ ☐ Unknown ☐ None	Legal Guardian ☐ Yes ☐ No Name ____________ Contact # ____________ Friend(s) ☐ Yes ☐ No ☐ Other

	Self	FAMILY HISTORY			
Diabetes (Endocrine):	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Thyroid Disease	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Cardiovascular Disease:	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Heart Attack	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Stroke	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
High Cholesterol:	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
COPD	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Emphysema	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Tuberculosis	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Dementia	☐	☐ Father	☐ Mother	☐ Brother	☐ Sister
Intellectually/Developmentally Disabled		☐ Father	☐ Mother	☐ Brother	☐ Sister
Mentally Ill		☐ Father	☐ Mother	☐ Brother	☐ Sister
Substance Use Disorder		☐ Father	☐ Mother	☐ Brother	☐ Sister
Cancer	☐ Yes	☐ Father	☐ Mother	☐ Brother	☐ Sister

Type ______________________________ Treatment ____

Other	☐ Yes	☐ Father	☐ Mother	☐ Brother	☐ Sister

RELIGIOUS/SPIRITUAL/CULTURAL

Religious Affiliation	☐ **None**
Attend Church?	☐ Yes ☐ No Method:
Cultural/Ethnic Practices That Impact Care/Teaching (Preferences List)	☐ **None**

Name: Case # or Last 4 SS#

CURRENT STATUS	PHYSICAL LIMITATIONS (Muscle/Skeletal System)	
☐ **NONE**	**Site**	**Degree**
Paralysis/paresis		
Contracture(s)		
Congenital Anomalies		
Prosthesis		
Other		

AMBULATION	WEIGHT BEARING	TRANSFERS	SUPPORTIVE DEVICES
☐ Independent	☐ Full Weight	☐ Independent	☐ Support Hose
☐ 1 Person Assist	☐ Partial Weight	☐ 1 Person Assist	☐ Hand Rolls
☐ 2 Person Assist	☐ Non-Weight Bearing	☐ 2 Person Assist	☐ Sheepskin
☐ With Device *(name)*		☐ Total Dependence	☐ Other *(list)*
________________		☐ Slide Board	________________
☐ WC only		☐ Mechanical Lift	________________
☐ Seat belt		(2 person assist)	
☐ Cushion		☐ Gait Belt	
☐ WC Propels Self		(1 Person Assist)	

GENERAL SKIN CONDITION: *(Check all that apply)*

	SITE	(Chronic-New Onset)			SITE	(Chronic/New Onset)	
☐ Dry		☐	☐	☐ Oily		☐	☐
☐ Edematous		☐	☐	☐ Cyanotic		☐	☐
☐ Pale		☐	☐	☐ Warm		☐	☐
☐ Moist		☐	☐	☐ Cold		☐	☐
☐ Reddened		☐	☐	☐ Jaundiced		☐	☐
☐ Ashen/Gray		☐	☐	☐ Other		☐	☐

REPRODUCTIVE HEALTH

PREGNANT ☐Yes ☐ No ☐NA LAST MENSTRUAL PERIOD:

SEXUALLY ACTIVE ☐Yes ☐ No BIRTH CONTROL/TYPE________________________________

VAGINAL/PENILE DISCHARGE ☐Yes ☐ No (If yes describe)

HX of STD's ☐Yes ☐ No (If yes describe)

NIPPLE DISCHARGE ☐Yes ☐ No ☐NA

LAST MAMMOGRAM PROSTATE EXAM

PERFORMS SELF BREAST/TESTICULAR EXAMS ☐Yes ☐ No ☐NA

EDUCATED on SELF EXAM ☐Yes ☐ No ☐NA

Name	Case # or Last 4 SS#

Hearing	R	L	Vision	R	L	Speech/Communication	
☐ Adequate			☐ Adequate			☐ Clear	
☐ Poor			☐ Poor			☐ Aphasic	
☐ Deaf			☐ Blind			☐ Verbal	☐ Nonverbal
☐ Hearing Aid			☐ Glasses/Contacts			Language/Communication method:	

Oral	Eating/Nutrition	Sleep
Own Teeth ☐ Yes ☐ No **(Circle)** Good/Fair/Poor **Cavities** ☐ Yes ☐ No __________ **Missing Teeth** ☐ Yes ☐ No __________ **DENTURES** ☐ Partial ☐ Full ☐ Upper ☐ Lower **Fit** ☐ Yes ☐ No	☐ Independent ☐ Needs Assist (see care plan) ☐ Aspiration Risk __________ ☐ Dysphagia (reason) __________ ☐ Adaptive Equipment *(type)* __________ **Diet Order** (Consistency/limitations) ☐ Regular ☐ Specific Define Type: ________ __________ __________ **Fluid Restriction** ☐ Yes ☐ No Amount:________	Usual Bedtime __________ Usual Arising Time __________ **Altered Sleep Pattern** ☐ Yes ☐ No Define: __________ __________ __________ __________ __________

Bathing/ Grooming	Independent	Assist	Total Depend
☐ Tub	☐	☐	☐
☐ Shower	☐	☐	☐
☐ Bed Bath	☐	☐	☐
Oral Hygiene	☐	☐	☐
Shave	☐	☐	☐
Shampoo	☐	☐	☐
Grooming	☐	☐	☐
Dressing	☐	☐	☐

Clothing/Shoes Fit Correctly ☐ Yes ☐ No

BOWEL AND BLADDER EVALUATION (GENTIAL/URINARY)

Bowel Continent		Bladder Continent		Frequent Constipation	
Other:		Other:			
☐ Y	☐ N	☐ Y	☐ N	☐ Y	☐ N
How managed?		How managed?		How managed?	

NAME	Case # or Last 4 SS#

PSYCHOSOCIAL FUNCTIONING

Oriented	☐Y ☐N ☐Person ☐Place ☐Time ☐Situation
General Appearance	☐Dressed/groomed appropriately for age/sex/situation ☐Disheveled ☐Pale ☐Emaciated ☐Sad ☐Happy
Level of Consciousness/ Behavior	☐ Alert ☐ Responsive ☐ Hyperactive ☐ Lethargic ☐ Combative ☐ Joyful ☐ Expressionless ☐ Tics/Tremors ☐ Pacing ☐ Cooperative ☐ Hostile ☐ Calm ☐ Rigid/Tense ☐ Compulsive ☐ Echolalia ☐ Other *(explain)*
Speech	☐ Talkative ☐Forced ☐Pressured/Excessive ☐ Nonverbal ☐Slurred ☐Impediment ☐ Loud ☐Illogical ☐Monosyllabic ☐ Other *(explain)*
Affect/Mood	☐ Appropriate ☐ Depressed ☐ Elated ☐ Anxious ☐ Guarded ☐ Flat ☐ Angry ☐ Cooperative ☐ Uncooperative ☐ Friendly ☐ Other *(explain)*
Thoughts	☐ Normal ☐ Guarded ☐ Flighty ☐ Wandering ☐ Disorganized ☐ Paranoid ☐ Illusions ☐ Delusional ☐ Hallucinations ☐ Homicidal ☐ Suicidal yes___ No___ Intent ___Plan______ ☐ Attention Level (ability to concentrate/easily distracted) ☐ Other *(explain)*
Memory	☐ Remote Memory (past) ☐ Delayed Recall (repeat after 5 minutes) ☐ Recent Memory
Insight	☐ Good ☐ Fair ☐ Poor (*What is causing your problem?)*
Judgment	☐ Good ☐ Fair ☐ Poor (*What would you do if you ran out of meds?)*

Personal Habits	Tobacco/Nicotine/other ☐ Yes / ☐ No List Product ___________ Amt./day ____________ Last Use_____________	Drinks Alcohol ☐ Yes / ☐No List Product _______ Amt./day ____ Last Use_______	Illegal Drug Use ☐ Yes / ☐ No Type/Freq______________ Amt./day______________ Last Use ______________
Have you received assistance to stop smoking? ☐ Yes / ☐ No If yes, when/where?__________________ ____________________________________ Are you interested in stopping? ☐ Yes / ☐ No		Have you received treatment for alcohol? ☐ Yes / ☐ No If yes, when/where?____ _________________ Are you interested in stopping?☐ Yes / ☐ No	Have you received treatment for substance use disorder? ☐ Yes / ☐ No If yes, when/where?__________ _______________________ Are you interested in stopping? ☐ Yes / ☐ No
Family Support	☐ Good ☐ Fair ☐ Poor	**Family Relationship**	☐ Good ☐ Fair ☐ Poor

NAME Case # or Last 4 SS#

CURRENT MEDICATIONS

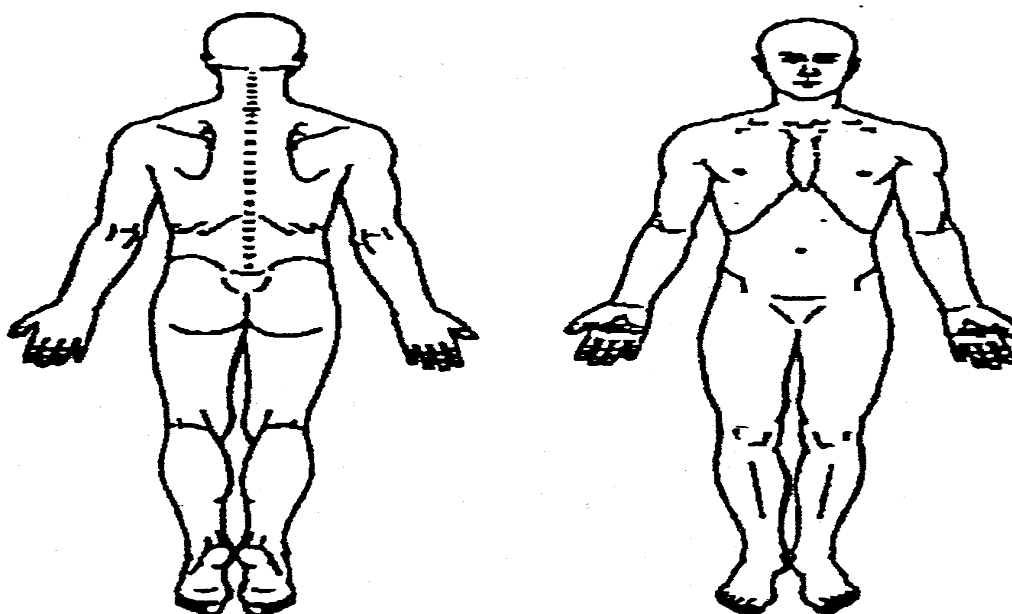
NAME	DOSE	FREQ	DIRECTIONS FOR USE	ROUTE	REASON	PHYSICIAN

AIMS COMPLETED? □ Yes □ No □ N/A
CHOKING ASSESSMENT COMPLETED? □ Yes □ No □ N/A
FALLS ASSESSMENT COMPLETED? □ Yes □ No □ N/A
SELF MEDICATION ADMINISTRATION ASSESSMENT COMPLETED □ Yes □ No □ N/A
(File in clinical record)

ATTACH ADDITIONAL SHEET IF NEEDED

MAS RN/LPN SIGNATURE____**DATE: __/__/____**

NAME Case # or Last 4 SS#



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

MAS RN SIGNATURE **DATE**

NAME	Case # or Last 4 SS#

Based on the problems listed the level of *nursing/medical care required* is:
(Select all that apply)

☐	**Skilled Nursing Only**
☐	MAC Worker Assistance with MAS Nurse Supervision 24/7
☐	Psychiatric status monitoring (state frequency)
☐	Medical/physical status monitoring (state frequency)
☐	
☐	Referral to: ☐PCP ☐Dentist ☐Optometrist ☐Other____

Based on the problems listed and the level of nursing/medical care required, the following *nursing interventions will be implemented* directly or via delegation (SELECT ALL THAT APPLY. ADD ADDITIONAL INTERVENTIONS AS NEEDED

□	Skilled Nursing □ 24 hours □ Intermittent (state frequency)
□	MAS Nurse Supervision of MAC Worker
□	Fall Precautions
□	Choking Precaution - Assist with meals
□	I & O (state frequency)
□	T/P/R/BP/O2 Sat/Wt. (state frequency)
□	Assisted ambulation/mobility/transfer
□	Assisted toileting/bathing
□	Monitor skin condition (state frequency)
□	Assisted communication
□	Lab (state frequency)________________ Date Due
□	Referral to service not provided by agency (List appointments made below)
	Appts:
□	MAS RN Care Plan(s) Completed
□	Assessment of ability to self-medicate completed (NDP 5) *Filed in clinical record*
	Other (Explain)

MAS RN NAME ________________________________ **DATE** ____________ **TIME** ______ **AM/PM**

MAS RN SUMMARY OF ASSESSMENTS

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MAS RN SIGNATURE/CREDENTIALS: ____________________________**DATE:** __/__/____