FORM ALF 102: Functional Screening for Assisted Living Facilities

Name:_____
(Last) (First) (MI)

Address: _____Phone #:_____

City/State/Zip: _____

DOB: ___/___/___ SSN: _____

Contact Person: _____Relationship: _____

Address: _____Phone #:_____

City/State/Zip: _____

Facility: _____

Anticipated Admit Date: _____

Referral Source: _____ Referral Date:_____

Significant Medical Conditions (include allergies): _____

_____

_____

_____

Instructions: **Check appropriate response under each category**. **Responses marked with an X will require the incorporation** of services provided by outside sources which will need to be listed on the bottom of the form.

1. MEDICATION ADMINISTRATION **(requires administration by licensed nursing staff. If licensed staff not available administration must be done by an outside contracted service.)**

- X ( ) a. Requires dose-related medical monitoring for cardiac rate depressors, hypertensives, insulin, anticoagulants, etc.
- X ( ) b. Frequent professional monitoring is required for need or dosage regulations, e.g., insulin, narcotics, anticoagulants, etc. Requires med box or insulin syringes filled by facility staff. Oxygen administration by facility staff.

2. **MEDICATION SELF MANAGEMENT**
- ( ) a. PRN self-administered medications or no medications.
- ( ) b. Requires minimal (1-4) self-administered medications on a regular basis, oral or topical, including vitamins.
- ( ) c. Requires multiple (5 or more) maintenance self-administered medications as a daily regime, oral or topical, including vitamins. Weekly or monthly self-administered injections.

3. **EATING/MEAL PREPARATION/DIET**
- ( ) a. Independently feeds self.
- ( ) b. Independently feeds self but needs someone to prepare meals.
- ( ) c. Requires occasional supervision to assure nutritional needs are met
- X ( ) d. Requires a therapeutic diet, i.e., renal dialysis diet.
- X ( ) e. Swallowing or choking precautions.
- X ( ) f. Requires constant attention and hand feeding by assistant, tube feedings. Requires monitoring of diet to assure nutritional needs are met.

4. **SKIN CARE, DRESSING, TREATMENT**
- ( ) a. Skin intact.
- ( ) b. Superficial skin conditions, fragility, rashes or chronic dermatitis.
- ( ) c. Pressure areas, small skin tear, with or without dressing, or minor skin lesions that are not infected.
- X ( ) d. Open skin lesions present (post-op wounds with complications, decubitus, and sterile/special dressings).

5. **SPEECH, VISION, HEARING**
- ( ) a. Unimpaired or impaired, but not dependent on assistance.
- ( ) b. Communication impairment that results in the need for occasional assistance.
- X ( ) c. Completely dependent in areas of communications.

6. **DRESSING AND PERSONAL GROOMING**
- ( ) a. Appropriate and independent dressing, undressing or grooming with little assistance (assist with TED hose/minor braces.
- ( ) b. Inability to button or zip or choose wardrobe.
- X ( ) c. Significant assistance or cuing needed on a regular basis.

7. **BATHING**
- ( ) a. Independent bathing with little assistance.
- ( ) b. Mobile, but unable to bathe without regular assistance and supervision. Occasional peri-care for hygiene.
- X ( ) c. Cannot bathe without total assistance (tub, shower, whirlpool, or bed bath.
- X ( ) d. Unable or unwilling to maintain an acceptable level of personal hygiene with minimal staff assistance.

8. **CONTINENCE**
- ( ) a. Continent of bowel and bladder.
- ( ) b. Occasional incontinence or stress incontinence, needs occasional help to clean self.
- X ( ) c. Frequent to total incontinence and unable to manage. his/her self; facility maintenance of colostomies and illeostomies.
- X ( ) d. Requires catheterization and catheter care by facility staff.

9 **MOBILITY**
- ( ) a. Independently and appropriately able to transfer and/or ambulate with or without a device.
- ( ) b. Able to transfer and/or ambulate with minimal or standby assistance.
- X ( ) c. Completely dependent, frequent transfers, frequent positioning, frequent falls, unable to evacuate building.
- X ( ) d. Requires a two-person transfer.

10. **BEHAVIOR/MOTIVATION**
- ( ) a. Appropriate behavior, well-motivated to, and capable of, performing ADLs.
- ( ) b. Intermittently confused and/or agitated; requires occasional reminders as to person, place, or time.
- ( ) c. Potential for substance abuse, including alcohol or prescription drugs, alone or in combination.
- X ( ) d. Frequently under the influence of alcohol or drugs, aggressive, abusive or disruptive.
- X ( ) e. Safety concerns. In danger of self-inflicted harm or self-neglect. Continuous surveillance required. Excessive wandering.

11. **SOCIALIZATION**
- ( ) a. Independent participation in social or therapeutic activities by choice. Isolated or reclusive by personal history.
- ( ) b. Requires special assistance or encouragement for participation in planned social activities.
- X ( ) c. Requires one-on-one assistance to maintain safety within the facility.

12. **MEDICAL CARE REQUIREMENTS**
- ( ) a. Medically stable.
- ( ) b. Acutely ill; able to maintain safely without 24 hour RN assessment, supervision.
- X ( ) c. Acutely ill; requires 24 hour RN care/supervision to ensure medical needs are met/addressed.
- X ( ) d. Requires skilled nursing care for chronic conditions.

Services beyond Assisted Living authority to be provided by the following outside entities.

Service	Service Provider	Physician	Arranged by

Signature of RN completing form: _____ **Date:** _____