INITIAL CONTACT/SCREENING FORM

Date: ____

Prospective Resident's Name: ____

Address____ Phone: _________________________

Age: ____________________ Height: ________________________ Weight: ________________________

Current Physical Health Condition: ____
____

Diagnosis and Prognosis: ____
____

Activities of Daily Living (ADL) Needs:

Independent: Does not require help of another person to perform a task.
Assistance: Requires the help of another person to perform part of a task.
Dependent: Requires the help of another person to perform all parts of a task.

	Independent	Assistance	Dependent
1. Personal Hygiene	☐	☐	☐
2. Bathing	☐	☐	☐
3. Dressing	☐	☐	☐
4. Eating	☐	☐	☐
5. Mobility/Transfer	☐	☐	☐
6. Toileting	☐	☐	☐
7. Housekeeping	☐	☐	☐
8. Emergency Exiting	☐	☐	☐
	_____ Total	_____ Total	_____ Total

Other Consideration:

Yes	No	
☐	☐	Smokes.
☐	☐	Uses alcohol. If yes, how much? ____
☐	☐	Manages own money.
☐	☐	Needs special diet. If yes, describe: ____

Nursing Care Needs (Delegated Tasks): ____
____

Mental Health/Behavior Problems: ____
____

Name of person giving information: ____

Relationship: ____ Phone: __________________________

Referred by: ____

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ACTION TAKEN
_____ Referral made to another Homes Plus/Adult Foster Care
_____ Admission information sent