Complete this form as best you can. It will help clarify, determine, and communicate what care your loved one needs. Remember to use the appropriate colum to document how much help is needed.

Basic Information

Basic Level Of Care Assessment Form

Resident's name:			Age	Sex
Medical Diagnosis:				
Current Medications list:				
Supplements and vitamins:				
Allergies:				
Current setting type (i.e. home, independent living):				
Primary Contact person:				Relationship:
Phone: (W)	(H)	(C)		email
Financial - What is the funding source?	Private pay	DSHS	Insurance	Other

Record how much assistance the resident needs with the following tasks.	Level of assistance needed				Comments
	Needs NO help, 100% independent	**Needs set-up and cueing, then can do alone**	**Needs partial help**	**Needs Extensive or total help**	
Activities of Daily Living					
Dressing Upper body					
Dressing Lower body, socks and shoes					
AM / PM hygiene Washing hand & face					
Comb hair, Brushing teeth, make up or shaving					
Personal Hygiene after toiletting or incontinance					
Toileting					
Bathing or Showering					
Transferring in & out of bed - in & out of chair					
Walks with cane or walker and…					
Is Wheelchair bound and…					
Meals: set up i.e. cutting foods etc.					
Eating, feeding self					
Bed mobility — Turning & positioning while in bed					

For assistance, contact Joseph Spada at (206) 550-4696

Bowel & Bladder Function

Circle appropriate functional status in the corresponding 'level of assistance needed' column. For example, can be continent but needs total help dressing & undressing to use bathroom.

Continent (can hold and control bladder & bowels)	bowel / bladder	bowel / bladder	bowel / bladder	bowel / bladder	
Occasionally incontinent (*once or twice weekly*)	bowel / bladder	bowel / bladder	bowel / bladder	bowel / bladder	
Incontinent (*more than twice weekly*)	bowel / bladder	bowel / bladder	bowel / bladder	bowel / bladder	
Wears full-time or part-time **incontinent briefs**	FT / PT	FT / PT	FT / PT	FT / PT	
Urinary **catheter**	Yes / No	Yes / No	Yes / No	Yes / No	

Mental & Cognitive Status

Is Alert & oriented to time, place, and person	Yes/No				
Is disoriented or confused *to time, place, or person*	Yes / No			Yes / No	
Memory loss - short-term	Yes / No		Yes / No	Yes / No	
Memory loss - Long-term	Yes / No		Yes / No	Yes / No	
Depression	Yes / No		Yes / No	Yes / No	
Wanders (specify if in daytime, night time, or both)			Yes / No	Yes / No	
Exit seeking - tries "to go home…"			Yes / No	Yes / No	
Difficult Behaviors: Unstable; disruptive; agitated; aggressive; soils in inappropriate places, etc. **Describe…**	Yes / No				

Other Items

Currently taking medication	No			Yes	
Needs Nursing or medical **treatments** (i.e. wound care)	Yes / No				
Needs Daily **pain** management	Yes / No				
Needs Injections (*daily—weekly—other*)	Yes / No	Yes / No	Yes / No	Yes / No	
Blood glucose monitoring	Yes / No	Yes / No	Yes / No	Yes / No	
Vital signs monitoring	Yes / No				
Is on O2 therapy (oxygen)	Yes / No	Yes / No	Yes / No	Yes / No	
Prescribed exercise or physical therapy	Yes / No	Yes / No	Yes / No	Yes / No	
Night Time Needs & Care (Any help required on a consistent basis between 9:00 p.m. and 7:00 a.m.)					

For assistance, contact Joseph Spada at (206) 550-4696