HIGHLAND
ASSISTED LIVING & MEMORY CARE

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Pre-Admission Initial Assessment Information

Today's Date: _____

Completed by: _____ ☐ Discharge Planner/Case Mgr. ☐ Social Worker
(name of preparer) ☐ Facility Rep. ☐ Family/Caregiver ☐ Other

Information sent by: ☐ FAX ☐ US MAIL ☐ Delivered in person ☐ Other _____

Date that information was sent: _____

Demographic Information: (you may attach a face sheet or other document to provide this information)

Name of Resident/Patient: _____

Age of Resident/Patient: _____ D.O.B.: ____ / _____/_____

Diagnosis: _____

Contact Information:

Name of DPOA, Guardian or Conservator: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Alternate/Cell: _____

Email _____

By providing answers to the following list of questions, you can help us to identify and understand the needs of the resident named above. This information will be used to form a preliminary assessment only.

1. **Would you say that this person's Alzheimer's/Dementia is?** ☐ Early Stage ☐ Middle Stage ☐ Late Stage ☐ End Stage
2. **Does this person have behavior issues that need to be managed**? ☐ No Issues ☐ Mild behavior ☐ Moderate behavior ☐ Severe behavior
3. **Describe the person's ability to ambulate:** ☐ Walks without assistance ☐ Walks with assistance ☐ Walks with a cane or walker ☐ Does not walk, needs a wheelchair
4. **Describe the person's level of agitation?** ☐ None ☐ Mildly agitated ☐ Severely agitated
5. **Is the person continent?** ☐ **No** ☐ **Yes**
   If yes, is it: ☐ Bladder only ☐ Bladder & bowel How often? ☐ Occasionally ☐ Frequently ☐ Most of the time
6. **Is this person living with…?** (check those that apply)
   ☐ Anxiety/Depression ☐ Psychiatric Disorders ☐ Sundowners syndrome ☐ Diabetes 1 or 2
   ☐ Congest. Heart Failure ☐ High/Low Blood Pressure ☐ Heart disease ☐ Kidney Disease
   ☐ Liver Disease ☐ Other Gastrointestinal Disorders ☐ Fainting ☐ Epilepsy
   ☐ Seizures ☐ Cancer: Type: _____ ☐ Other_____
7. **Does this person have any additional special needs?**
   ☐ Special Diet ☐ Fluid restriction ☐ Food Allergies ☐ Other _____
8. **Does this person have a history of falling?** ☐ **No** ☐ **Yes**
   If yes, how frequently in the last six months? ☐ Once ☐ 2 to 4 times ☐ 5 times or more
9. **Does this person need help with activities of daily living?** (check any that apply)
   ☐ Dressing ☐ Grooming ☐ Bathing ☐ Toileting ☐ Taking Medications
   ☐ Eating ☐ Socialization ☐ Physical Activity ☐ Communication