SNF/LTC INITIAL ASSESSMENT Please fax completed form to your facility's assigned SFHP Nurse.



All questions contained in this questionnaire are strictly confidential and will become part of the Residents' medical record.

Name (Last, First,	M.I.):		D	OB:	Α	uth#:		Admission	Date:	
Facility:					Attending:					
Admit Dx:					H	eight:		Weight:		
Co-Morbidities:					•••••					
Admit Level of (Care: 🗆 Sub acute	🗆 Level 4 🗆 L	evel 3 🗆 Leve	2 □ Level	1 🗌 Cus	todial				
lustification for	Level:									
D/C Plan: 🗆 LTC	🗆 B&C 🗆 Home	□ Home with	HH 🗆 Home w	vith CBAS 🗆] Home wi	th IHSS		#hrs/month:		
Current Barriers	to D/C Plan:				•••••					
Freatment Goals	:	••••••			••••••					
Prior Living Con	ditions:				•••••					
Prior Level of Fu	nction:				•••••					
Does Resident h	ave social or famil	y support?	∕es □ No Des	cribe:	••••••					
	wn DME? 🗆 Yes [ññññ.			•••••					
	ave income? 🗆 Ye		nuch per mon	th?						
	ave an Advance D	· · · · · · · · · · · · · · · · · · ·			D	POA:		Phone Num	ber:	
	cility Provide Tran	•••••••••••••••••••••••••••••••••••••••			iī.			<u>.</u>		
	ortation Needs: \Box	··· ⁷ ·····			Other			·····		
······································	ave the potential t	····· · ········			· · · · · · · · · · · · · · · · · · ·	5 🗆 No	If No	, Why?		
	·	5	,	-			·			
PATIENT SUPPO	RT/CAREGIVER									
Name (Last, First,	M.I.):				Relationship:					
Address:					EI	mail:				
Douter to Cian Co		••••••			· · · · · · · · · · · · · · · · · · ·			· · · · · · · · · · · · · · · · · · ·		
arty to sign Co	ntract:									
	ntract:	Cell Nu	nber:		W	/ork Nu	mber:			
Home Number:	ETY & ACTIVITY LE			eck all conditi			mber:			
Home Number: PERSONAL SAF		VEL Resident C		eck all conditi			mber:			
Dietary Requirer	ETY & ACTIVITY LE	VEL Resident C	are Needs (Che	eck all conditi □ Trach			mber:	□ Surgical	□ Pressure	
Home Number: PERSONAL SAF Dietary Requirer Chemo	ETY & ACTIVITY LE ments/Restrictions	VEL Resident C	are Needs (Che			oply)		□ Surgical □ Arterial	□ Pressure #:	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy	ETY & ACTIVITY LE ments/Restrictions:	VEL Resident C	are Needs (Che	□ Trach □ Other:	ons that a	oply) v	mber: Vounds	-	#:	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube	VEL Resident C	are Needs (Che □ O2 □ Smoker	□ Trach □ Other:	ons that a	oply) v		□ Arterial	-	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube	VEL Resident C	are Needs (Che	TrachOther:Suctionin	ons that ap	oply) y: V	Vounds	□ Arterial □ Venous	#:	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have	VEL Resident C	are Needs (Che	TrachOther:Suctionin	ons that a	oply) y: V	Vounds	□ Arterial □ Venous	#:	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident exper	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes 	ons that an g/Frequence	oply) y: V □ How	Vounds v many:	 Arterial Venous Foot Wounds 	#: Stage(s):	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident exper Does Resident have	VEL Resident C Ileostomy Isolation NG Tube NPO stairs at home? ience frequent fal vision or hearing	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes Yes 	ons that an g/Frequence No No No	y: V Glass	Vounds v many: sses	Arterial Venous Foot Wounds Hearing Aid	#: Stage(s):	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident have Does Resident have Indicate all appropria	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee 	ons that ap g/Frequence No No Ichair	y: V G Hov	Vounds v many: sses e	Arterial Venous Foot Wounds Hearing Aid Walker	#: Stage(s): ds Other:	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident exper Does Resident have Indicate all appropria	VEL Resident C Ileostomy Isolation NG Tube NPO stairs at home? ience frequent fal vision or hearing	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee Indep 	ons that an g/Frequence D No No Ichair endent	y: V Glas Glas Can May	Vounds v many: sses e (Assist	 Arterial Venous Foot Wounds Hearing Air Walker Mod 	#: Stage(s):	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Cona Dialysis/Days Personal Safety	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident have Does Resident have Indicate all appropria Ambulation Safety/Balance	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee 	ons that an g/Frequence D No No Ichair endent	y: V G Hov	Vounds v many: sses e (Assist	Arterial Venous Foot Wounds Hearing Aid Walker	#: Stage(s): ds Other:	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety Current Level of	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident have Does Resident have Indicate all appropria Ambulation Safety/Balance	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee Indep 	ons that an g/Frequence D No No Ichair endent	y: V Glas Glas Can May	Vounds v many: sses e (Assist	 Arterial Venous Foot Wounds Hearing Air Walker Mod 	#: Stage(s): ds Other:	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety Current Level of Discharge Plan:	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident exper Does Resident exper Does Resident have Indicate all appropria Ambulation Safety/Balance Functioning:	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee Indep 	ons that an g/Frequence D No No Ichair endent	y: V Glas Glas Can May	Vounds v many: sses e (Assist	 Arterial Venous Foot Wounds Hearing Air Walker Mod 	#: Stage(s): ds Other:	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety Current Level of Discharge Plan: ADMISSION PA	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident have Indicate all appropria Ambulation Safety/Balance Functioning:	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee Indep 	ons that an g/Frequence D No No Ichair endent	y: V Glas Glas Can Fair	Vounds v many: sses e c Assist	 Arterial Venous Foot Wounds Hearing Aid Walker Mod Poor 	#: Stage(s): ds Other: Min	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety Current Level of Discharge Plan: ADMISSION PAG Facesheet	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident have Indicate all appropria Ambulation Safety/Balance Functioning:	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee Indep 	g/Frequence	y: V Gase Can Can Aay Fair	Vounds v many: sses e c Assist SNF/L	 □ Arterial □ Venous □ Foot Wounds □ Hearing Aid □ Walker □ Mod □ Poor TC Initial	#: Stage(s): ds Other: Min Yes I No	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety Current Level of Discharge Plan: ADMISSION PA Facesheet Physician Orders	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident exper Does Resident have Indicate all appropria Ambulation Safety/Balance Functioning:	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee Indep Good 	ons that an g/Frequence D No No Ichair endent	y: V Glas Glas Can Aay Fair	Vounds v many: sses e c Assist SNF/L Thera	 Arterial Venous Foot Wounds Hearing Aid Walker Mod Poor 	#: Stage(s): ds Other: Min Yes I No	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety Current Level of Discharge Plan: ADMISSION PA	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident exper Does Resident have Indicate all appropria Ambulation Safety/Balance Functioning:	VEL Resident C	are Needs (Che	 Trach Other: Suctionin Yes Yes Yes es: Whee Indep Good 	g/Frequence	y: V Glas Glas Can Aay Fair	Vounds v many: sses e c Assist SNF/L Thera	Arterial Venous Foot Wounds Hearing Aid Walker Nod Poor TC Initial py Evaluation (Sk	#: Stage(s): ds Other: Min Yes No illed) Yes No	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety Current Level of Discharge Plan: ADMISSION PA Facesheet Physician Orders FT (Inter-facility tr MC171	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident exper Does Resident have Indicate all appropria Ambulation Safety/Balance Functioning:	VEL Resident C Ileostomy Isolation NFO stairs at home? ience frequent fal vision or hearing ate assistive devic x ft. LEASE SEND WIT fes No MD fes No H 8 fes No Wo fes No	are Needs (Che	□ Trach □ Other: □ Suctionin □ Yes □ Yes □ Yes es: □ Whee □ Indep □ Good	g/Frequence	y: V Glas Glas Can Aay Fair	Vounds v many: sses e c Assist SNF/L Thera	Arterial Venous Foot Wounds Hearing Aid Walker Nod Poor TC Initial py Evaluation (Sk	#: Stage(s): ds Other: Min Yes No illed) Yes No	
Home Number: PERSONAL SAF Dietary Requirer Chemo Colostomy Coma Dialysis/Days Personal Safety Current Level of Discharge Plan: ADMISSION PA Facesheet Physician Orders FT (Inter-facility tr MC171	ETY & ACTIVITY LE ments/Restrictions: Eloper/Wanderer Foley Cath G/J Tube HHN Does Resident have Does Resident have Indicate all appropria Ambulation Safety/Balance Functioning: CKET CHECKLIST (P Sansfer form)	VEL Resident C Ileostomy Isolation NFO stairs at home? ience frequent fal vision or hearing ate assistive devic x ft. LEASE SEND WIT és No MD és No H 8 és No Wo es No	are Needs (Che	□ Trach □ Other: □ Suctionin □ Yes □ Yes □ Yes es: □ Whee □ Indep □ Good	g/Frequence	y: V Glas Glas Can Aay Fair	Vounds v many: sses e c Assist SNF/L Thera Assig	Arterial Venous Foot Wounds Hearing Aid Walker Nod Poor TC Initial py Evaluation (Sk	#: Stage(s): ds Other: Min Yes No illed) Yes No	