NORTHSHORE HEIGHTS, LLC
8804 South Northshore Drive
Knoxville, TN 37922
Pre-Admission Assessment

Resident Name_____ Diagnosis: _____

Hygiene:
_____ Independent – No Assistance Required
_____ Minor Assistance Needed – Reminders for personal care and grooming
_____ Major Assistance – Preparation / Setup of materials – Prompting or Cueing
_____ Hands on Assistance Required – Hand over Hand assistance or Staff Leads

Dressing:
_____ Independent – No Assistance Required
_____ Minor Assistance Needed – Reminders to change, zippers/buttons, tie shoes, etc
_____ Major Assistance – Structured Routine - Prompting or Cueing
_____ Hands on Assistance Required

Mobility:
_____ Independent – No Assistive Devices Required
_____ Uses Wheelchair, Walker, or Cane
_____ Requires reminders for Safety to use assistive device – Fall Risk
_____ Needs assistance of 1 with transfers to chair, bed, etc.

Eating:
_____ Independent – Arrives at meals on time without reminders
_____ Assistance Needed to open items – Meat cut up
_____ Reminders and Monitoring to attend Meals
_____ Special Diet Monitoring – Dietary Supplements

Medication:
_____ Independent – Self medicates appropriately – can maintain medications secured in apartment
_____ Assistance Required but can Self Administer Medications with proper dosages on predetermined schedule
_____ Medications require to be crushed

Continence:
_____ Independent – No difficulties with Bladder or Bowel Continence
_____ Occasional Incontinence – Uses Pads or Liners
_____ Minor Assistance Needed – Reminders or Assistance to toilet – Bathroom Schedule required
_____ Uses Briefs through Night Only
_____ Dependent on Brief through Day and Night Hours

Sleep Pattern:
_____ Sleeps through the night without difficulty
_____ Requires Medication to Sleep
_____ Awakens frequently or Naps through Day

Mental Status:
_____ Oriented
_____ Confusion – at times – difficulty remembering details
_____ Moderate Impairment – Short Term Memory – Requires Orientation
_____ Behavior Problems associated with Dementia/Depression/Anxiety/Agitation

Please Describe Behavior Problems: _____
_____

Additional Comment: _____
_____

We have examined/evaluated _____, and find that this resident is appropriate for Assisted Living Care.

Interdisciplinary Review Signatures

Wellness Director: _____ Date: ____/____/_____

Physician: _____ Date: ____/____/_____

Social Worker: _____ Date: ____/____/_____

Registered Nurse: _____ Date: ____/____/_____

Family Member: _____ Date: ____/____/_____