Resident Service Plan

NAME: _____ **DATE:** _____

ACTIVITIES OF DAILY LIVING

	Level of Assistance Required					Comments
Eating:	None	Supervise	Assist	Total Help	Special Diet	
Dressing:	None	Supervise	Assist	Total Help		
Grooming:	None	Supervise	Assist	Total Help		
Toileting:	None	Reminder	Assist to bathrooms	Assist with briefs	Bedside Commode	
	Awaken at night	Catheter Assist				
Bathing:	None	Supervise	Assist	Total Help		
	Shower	Bath	Shave	Shampoo		
Frequency:						
Ambulation:	None	Standby	Cane /Walker	Wheelchair	Gait Belt	
Transfer:	None	Standby	Total Assist			
Communication / Sensory Aids	Glasses	Hearing Aid	Blind / Limited Eye Sight	Face Resident when Talking		
Dental / Oral Care:	Dentures	Reminders - brush/clean	Assist - brush/clean			
Nutrition:	Monitor Weight	Record food consumption	Monitor liquid intake	Encourage to eat		
Frequency:						
Sleep Patterns:	No nighttime monitoring	Check every ____ hours at night	Stays up late	Awaken in morning at _____	Naps during day	

SOCIAL / ACTIVITY PROGRAM

Social Program:	Group Games	Shopping/ Outings	Gardening	Religious Programs	Other	
Involvement:	Encourage coming out of room	Provide one on one involvement	Encourage participation in group	Does not want to be involved in group	Encourage family / friend visits	

NAME:_____

BEHAVIORAL / PSYCHOLOGICAL

Behaviors to Monitor / Be Aware of:	Aggressive Behavior	Obsessive / Compulsive	Bi-Polar	Angry	Withdrawn	
	Anxious	Sad Mood				
Cognitive Skills / Decision Making Ability	Independent / Alert	Needs some help in understanding / making decisions	Can understand simple directions	Unable to understand most directions		

MEDICAL

Medication:	Self-Administer	Supervision	Administration			
Preventative Health Needs:	Monitor Blood Pressure	Assist in Monitoring Blood Sugar	Needs Hearing & Vision Assessment			
Frequency:						
Allergies:	Food	Medicine	Other			

Health Conditions and Possible Medication Side Effects to Monitor:

Special Instructions:

DO NOT RESUSCITATE ORDER ON FILE:	**YES**	**NO**	

Manager or Designee Signature: _____ **Date:** _____

Resident or Responsible Party Signature: _____ **Date:** _____

Individual Resident Assessment

Resident:_____ Date:_____

Previous Address: _____ City:_____ State:_____

Date of Birth: _____ Height:_____ Weight: _____

Primary Language: _____

Eating:	☐ **Independent**	☐ **Supervision**	☐ **Assist**	☐ **Total Help**
Dressing:	☐ **Independent**	☐ **Supervision**	☐ **Assist**	☐ **Total Help**
Grooming:	☐ **Independent**	☐ **Supervision**	☐ **Assist**	☐ **Total Help**
Continence Status:	☐ **Independent**	☐ **Reminders**	☐ **Assist**	☐ **Total Help**
	☐ **Adult Briefs**	☐ **Awaken at night**	☐ **Catheter Assist**	
Bathing:	☐ **Independent**	☐ **Supervision**	☐ **Assist**	☐ **Total Help**
Bathing Time / Type:	☐ **Morning**	☐ **Night**	☐ **Shower**	☐ **Bath**
Ambulation:	☐ **Independent**	☐ **Supervision**	☐ **Assist**	☐ **Total Help**
Transfer:	☐ **Independent**	☐ **Supervision**	☐ **Assist**	☐ **Total Help**
Special Aids:	☐ **Cane**	☐ **Walker**	☐ **Wheelchair**	☐ **Other**
Communication:	☐ **Able to communicate with others**	☐ **Hearing Aid**	☐ **Glasses**	
Oral/Dental Status:	☐ **Dentures**	☐ **Reminders to brush/ clean**	☐ **Total oral assistance**	
Diet:	☐ **Regular**	☐ **Low Salt**	☐ **Low Sugar**	☐ **Low Fat**
Nutritional Status:	☐ **Recent Weight Changes: _____**	☐ **Nutritional Problems: _____**	☐ **Needs encouragement to eat**	☐ **Special Approaches to ensure good nutrition:_____**
Sleep Patterns	☐ **Sleeps well at night**	☐ **Light sleeper but independent**	☐ **Requires night supervision**	
Involvement Patterns:	☐ **Daily contact - relatives/friends**	☐ **Enjoys group activities**	☐ **Usually attended religious services**	☐ **Does not like to be alone**
Cycle of Daily Events:	☐ **Napped regularly**	☐ **Stayed up late at night**	☐ **Spent most of time alone watching TV etc.**	
Activity Pursuit:	☐ **Group Activities: _____ _____**	☐ **Religious Activities:_____ _____**	☐ **Gardening, cooking, homemaking**	☐ **Other:_____ _____ _____**

Resident:_____

Mental Health History:_____

Alzheimer's/Dementia History:_____

Psychosocial Issues: _____

Cognitive Skills-daily decision making:	☐ **Independent**	☐ **Modified Independence**	☐ **Moderately Impaired**	☐ **Severely Impaired**
Behavioral / Psychological Symptoms:	☐ **Aggressive**	☐ **Obsessive / Compulsive**	☐ **Bi-Polar**	☐ **Angry**
	☐ **Withdrawn**	☐ **Depressed/Sad**	☐ **Anxious**	☐ **Not Applicable**
Medication:	☐ **Self-Administer**	☐ **Supervision**	☐**Administration**	
Preventative Health Needs:	☐ **Blood Pressure Monitoring**	☐ **Hearing / Vision Assessment**	☐ **Glucose (Blood Sugar) Monitor-ing Assistance**	

Diagnoses:_____

Allergies:_____

Health Conditions and Possible Medication Side Effects: _____

_____

Special Treatments and Procedures:_____

_____

Hospital Admissions within the past six months or since last assessment:

_____

Special Instructions / Comments:

_____

_____

_____

_____ _____

Resident or Responsible Party Signature **Date**

_____ _____

Facility Representative Signature **Date**