

DAUGHTERS OF SARAH NURSING CENTER

**SOCIAL SERVICES
PSYCHOSOCIAL ASSESSMENT
(complete upon admission)**

Name:		Age:
Date of Birth:	Religion:	
Primary Language:	Other Language:	
Admission Date:	Admitted from:	
Factors causing admission to DOS:		
• Reason for Placement:	<input type="checkbox"/> Physical illness necessitating a structured health care living situation.	
	<input type="checkbox"/> Dementia-related illness necessitating a structured living situation.	
	<input type="checkbox"/> Psychiatric illness necessitating a structured living situation.	
	<input type="checkbox"/> The primary caretaker is no longer able to provide care.	
	<input type="checkbox"/> Other:	
• Personal Information:		
Place of Birth:		
Name of Parents:		
Siblings (by birth order)	1.	3.
	2.	4.
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	
Children:		
Grandchildren:		
Education:		Occupation:
Interest, Hobbies: <input type="checkbox"/> Arts & Crafts <input type="checkbox"/> Reading <input type="checkbox"/> Music <input type="checkbox"/> Exercise <input type="checkbox"/> Outings <input type="checkbox"/> Group/Clubs <input type="checkbox"/> Religious <input type="checkbox"/> Audiovisual <input type="checkbox"/> Games		
Organizational Affiliations:		Place of Worship:
Significant Losses or Changes:		
Any previous history of nursing home stays:		
• Physical Functions:		
Mobility Status:	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker/Cane <input type="checkbox"/> Ambulates
Auditory:	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
Visual Status:	<input type="checkbox"/> Glasses	<input type="checkbox"/> Legally Blind <input type="checkbox"/> Cataracts
Adaptive Equipment (if short term rehab): (If short term rehab, complete the following)		
If Short Term Rehab, Complete This Section:		
• Living Arrangements Prior to Admission:		Phone #:
Address:		
Lives with:		
Return to:		
<input type="checkbox"/> Home		
<input type="checkbox"/> Assisted Living		
<input type="checkbox"/> Other		
Home Care Services		
Cooking	<input type="checkbox"/> Self	<input type="checkbox"/> Other (please specify)
Cleaning	<input type="checkbox"/> Self	<input type="checkbox"/> Other (please specify)
Shopping	<input type="checkbox"/> Self	<input type="checkbox"/> Other (please specify)

Transportation	<input type="checkbox"/> Self	<input type="checkbox"/> Other (please specify)
Self Administration Medication		
Community Physician		
Telephone #:		
Support Network		
Insurance Contact:		
Telephone #		
Discharge Plan: (Probable Discharge Plan/Resident and Family Goals to return home):		
• D/C Potential:		
Anticipated Length of Stay:		
<input type="checkbox"/> Greater than 90 days		
<input type="checkbox"/> Less than 90 days		
<input type="checkbox"/> Unknown		
Resident's Understand/Feeling about current status/placement		
• Customary Routine (During Year Before Admission)		
Please check all below that apply to the resident. If all is unknown to you, check off #5 All Unknown		
Cycle of Events:		
<input type="checkbox"/> Stays up late at night (after 9:00 PM)		
<input type="checkbox"/> Naps regularly during day (at least one hour)		
<input type="checkbox"/> Goes out one or more days a week.		
<input type="checkbox"/> Stays busy with hobbies, reading, fixed daily routine		
<input type="checkbox"/> spends most time alone or watching TV		
<input type="checkbox"/> Moves independently indoors (with applicant, if used)		
<input type="checkbox"/> Use of tobacco products at least daily		
<input type="checkbox"/> NONE OF THE ABOVE		
Eating Patterns		
<input type="checkbox"/> Distinct food preferences		
<input type="checkbox"/> Eats between meals all or most days		
<input type="checkbox"/> Use of alcoholic beverage(s) at least weekly		
<input type="checkbox"/> NONE OF THE ABOVE		
Hygiene Patterns		
<input type="checkbox"/> In bed clothes much of day		
<input type="checkbox"/> Wakens to toilet all or most nights		
<input type="checkbox"/> Has irregular bowel movement patterns		
<input type="checkbox"/> Prefers showers for bathing		
<input type="checkbox"/> Prefers bathing in PM		
<input type="checkbox"/> NONE OF THE ABOVE		
Involvement Patterns:		
<input type="checkbox"/> Daily contact with relative/close friends		
<input type="checkbox"/> Usually attends church, temple, synagogue		
<input type="checkbox"/> Finds strength in faith		
<input type="checkbox"/> Daily animal companion/presence		
<input type="checkbox"/> Involved in group activities		
<input type="checkbox"/> NONE OF THE ABOVE		
Information provided by:		
Signature of Social Worker:		Date: