HIGHLAND
ALZHEIMER'S CARE
Telephone: 517-782-1900 • Fax: 517-784-8537

Pre-Admission Initial Assessment Information

Today's Date: _____

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

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

Contact Information:
Name of DPOA, Guardian or Conservator: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone #: _____ Alt/Cell: _____
E-mail: _____

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 persons 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 ❑ Moderately agitated ❑ Severely agitated

5) Is the person incontinent? ❑ No ❑ Yes
If yes, is it: ❑ bladder only ❑ bladder and bowel How often? ❑ Occasionally ❑ Frequently ❑ Most of the time

6) Is this person living with…? *(check those that apply)*
❑ Anxiety/Depression ❑ Psychiatric disorders ❑ Sundowner's syndrome ❑ Diabetes I or II
❑ Congestive 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: *(check option or fill in the blank)*
❑ Special diet ❑ Fluid restriction ❑ Food allergies ❑ Other _____

8) Does this person have a history of falling? *(check the appropriate response)* ❑ No ❑ Yes
If yes, how frequently in the last 6 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