WALLICK

RN HEALTH ASSESSMENT

MOVE-IN ☐ **ANNUALLY** ☐ **CHANGE OF CONDITION** ☐

Resident:	**Assess Date:**	**Apartment:**
Physical & Mental Health History, Chronic Conditions & Duration, **Has the Resident had a history of mental illness, mental retardation or development disability?**	**Allergies:** **Diet:**	
Medication Required (initial assessment only): **For all PRN Medications, see MAR's**		
Health Related Services Required:		
Ancillary Provider Required:		
Equipment Needed: ☐ Glasses ☐ Hearing Aids ☐ Dentures ☐ Cane ☐ Walker ☐Wheelchair ☐ Other:		

Vital Signs: **BP**	**P**	**R**	**T**	* **WT**	* **WT Change**

PSYCHO-SOCIAL:

Mental Status & Behavioral Issues:	**No**	**Yes**	**Comments:**
Memory Impaired	☐	☐	
Diagnosis of Dementia	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Paranoia/Delusion	☐	☐	
Agitation	☐	☐	
Sundowning	☐	☐	
Ability to leave residence unsupervised	☐	☐	

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Other Behavioral Issues/Changes (Wandering, physical or verbal aggression, sexually inappropriate behaviors, etc.):

Review of Systems:

	Describe/Comments
Eyes	
Ears	
* Mouth	
Hair	
Nails	
Skin (see below)	
Feet	
Head/Neck	
Breast	
Chest/Lungs	
Cardiac	
Bladder	
* Bowel	
Abdomen	
* Peripheral	
Musculoskeletal	
Falls	
* Nutrition	
* Chewing, Swallowing	

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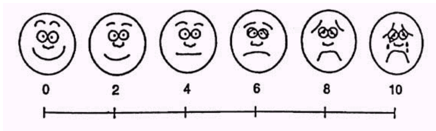
Sleep	
Pain (see below)	
Restraints/devices	

* **If problems are noted, refer to and/or initiate a nutrition intervention program.**

Pain Management (Specify location and degree of pain):



Pain Management (specify location and degree of pain)

Does medication help the pain?

Skin Assessment

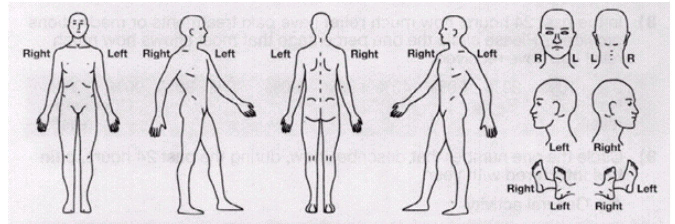
❑ Intact

❑ Rash-Location________________________________

❑ Type: Macular, Papular, Yeast, Other____________________________

❑ Bruises- Location________________________________

❑ Wound- Circle on Body Diagram below



Wound Description

Description of Site	Size (weekly)			Drainage			Description of Surrounding Skin Appearance	Pain
	L	W	D	Amount	Color	Odor		(1-10)
__ clean / pink __%				__ amount	__ serous	__ yes	__ normal color	
__ granular __%				__ scant	__ sang	__ no	__ intact	
__ yellow / slough __%				__ small	__ yellow		__ edematous	
__ necrotic __%				__ moderate	__ tan		__ dry / flaky	
__ Blistered __%				__ large	__ green		__ red	
							__ cracking	

Braden Scale for Predicting Pressure Sore Risk

Sensory	Moisture	Activity	Mobility	Nutrition	Friction & Shear

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Perception					
1. Completely Limited	1. Constantly Moist	1. Bedfast	1. Completely Immobile	1. Very Poor	1. Problem
2. Very Limited	2. Very Moist	2. Chairfast	2. Very Limited	2. Probably Inadequate	2. Potential Problem
3. Slightly Limited	3. Occasionally Moist	3. Walks Occasionally	3. Slightly Limited	3. Adequate	3. No Apparent Problem
4. No Impairment	4. Rarely Moist	4. Walks Frequently	4. No Limitation	4. Excellent	

Total Score______

❑ Braden Score is 16 or less. *Prevention Intervention is needed if score is under 16.*

Prevention Intervention Comments: ____

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____

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Modes of Communication

	(check all that apply)	Comments
Verbal		
Written		
Gestures		
Utilizes Communication Board		

Decision Making Authority (check boxes only if paperwork is in chart)

	(check all that apply)	Comments
Self		
POA for Financial		
POA for Healthcare		
Guardianship		
Family Relationship_________________________________		

RN Signature: ____**Date**_________________

This information was obtained from resident/responsible party/associates and medical record:

Signature of Resident when possible:____