



# Resident Intake Form

Purpose of Intake Form: **(THIS IS NOT A TRANSFER FORM)**

Staff/Title (from referring facility): \_\_\_\_\_

1. Screening tool before acceptance into LTC/Skilled Facility

2. Identify resident needs prior to arrival

3. Identify information for MDS coordinator/submission of data

Date Information Received: \_\_\_\_\_

## GENERAL

Name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Referral Facility: \_\_\_\_\_

## BEHAVIORAL/MOBILITY

History of falls? Yes / No      Recent history of restraint use? Yes / No

If yes, what type of restraint used? \_\_\_\_\_

Has patient been on ventilator in the past 3 months? Yes / No

Does resident have a tracheostomy? Yes / No

Cognition: alert \_\_\_\_\_ confused \_\_\_\_\_ comatose \_\_\_\_\_

Does resident have behavioral issues? Yes / No

Elopement risk? Yes / No

Does patient have **impaired** bed mobility and/or self-performance of transfer? Yes / No

(If yes, notify MDS Coordinator)

## ELIMINATION

History of urinary tract infection: Yes / No      Date of last UA: \_\_\_\_\_

Hx of incontinence? (If yes, circle urinary, bowel, or both if applicable) Urinary Bowel Yes / No

Hx of fecal impaction: Yes / No      Hx of dehydration: Yes / No

Does resident have urinary or fecal diversion? Yes / No

If yes, which type? Colostomy \_\_\_\_\_ Ileostomy \_\_\_\_\_ Urostomy \_\_\_\_\_

Does patient have indwelling catheter or suprapubic catheter? Yes / No

If patient has had catheter, date of catheter removal: \_\_\_\_\_

## PAIN

Does resident have pain? Yes / No      If Yes, location/etiology: \_\_\_\_\_

Is pain well controlled with meds? Yes / No      If Yes, what meds? \_\_\_\_\_

## SKIN/WOUND

Braden or Norton Score: \_\_\_\_\_      Score of other PU risk assessment: \_\_\_\_\_

Does resident have a wound? Yes / No      If Yes, location: \_\_\_\_\_

Type of wound: pressure ulcer \_\_\_\_\_ venous stasis ulcer \_\_\_\_\_ arterial ulcer \_\_\_\_\_

diabetic ulcer \_\_\_\_\_ maceration/excoriation \_\_\_\_\_ skin tear \_\_\_\_\_

other \_\_\_\_\_

**SKIN/WOUND CONTINUED**

Is there a written diagnosis from the physician for any of the previous wounds? Yes / No  
If yes, what is the diagnosis (notify the MDS Coordinator)? \_\_\_\_\_  
Will resident need specialty bed and wound treatments? Yes / No

**INFECTION CONTROL**

Are there symptoms/evidence of infection: **Local** Yes No (circle one) Please specify type: \_\_\_\_\_  
**Systemic** Yes No (circle one) Please specify type: \_\_\_\_\_

Besides universal (standard) precautions, are there any other forms of isolation recommended for this Pt/Resident? **Yes** No (circle one) Please specify type of isolation: \_\_\_\_\_

**NUTRITIONAL**

Gastrostomy/PEG tube? Yes / No Nutritional supplements? Yes / No  
Recent weight changes? Yes / No

If yes, (loss or gain) how much? \_\_\_\_\_ lbs/Kg

Current weight: \_\_\_\_\_ lbs/Kg Current height: \_\_\_\_\_ ft \_\_\_\_\_ in

Recent Swallow Study? Yes / No If yes, is patient on swallow precautions? Yes / No

Nutritional labs - date and value: (enter value and circle normal or low)

Albumin level \_\_\_\_\_ Normal/Low Pre-albumin level \_\_\_\_\_ Normal/ Low  
Total Protein level \_\_\_\_\_ Normal/Low

Is patient at nutritional risk? Yes / No

If yes, does resident have one of the following diagnoses?

- \_\_\_\_\_ 260 Kwashiorkor (protein malnutrition, malignant malnutrition)
- \_\_\_\_\_ 261 Nutritional marasmus (severe deficiency of nutrients, esp. calories and protein)
- \_\_\_\_\_ 262 Other severe, protein-calorie malnutrition
- \_\_\_\_\_ 263.0 Malnutrition of moderate degree
- \_\_\_\_\_ 263.1 Malnutrition of mild degree
- \_\_\_\_\_ 263.2 Arrested development following protein-calorie malnutrition
- \_\_\_\_\_ 263.8 Other protein-calorie malnutrition
- \_\_\_\_\_ 263.9 Unspecified protein-calorie malnutrition

Is there a written physician diagnosis for any of the above? (If yes, notify MDS Coordinator) Yes / No

If resident is at nutritional risk (labs, weight loss, eating difficulties) has physician been called for a diagnosis listed above?

Yes, written in chart: \_\_\_\_\_

No, unable to obtain: \_\_\_\_\_

Comments:

\_\_\_\_\_

Above Intake assessment completed by:

\_\_\_\_\_

Signature

\_\_\_\_\_

Date