StrongBase Senior Placement Services, LLC  
 Assessment

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Patient | | | | | | | | | | | | | | | Home Phone | | | | | | | DOB |
| Address | | | | | | | | | | | | | | | State/Zip | | | | | | | Height/Weight |
| Name of POA/Family ⃝ POA Paperwork received | | | | | | | | | | | | | | | Phone | | | | | | | Email |
| 1. Current Diagnosis | | | | | | | | | | | | | | | | | | | | | | |
| 2. Physical Limitations | | | | | | | | | | | | | | | | | | | | | | |
| 3. Mental Health Limitations | | | | | | | | | | | | | | | | | | | | | | |
| 4. Treatment/Therapies | | | | | | | | | | | | | | | | | | | | | | |
| 5. Diet: (Salt/Sweet) | | | | | | | | | | | | | | | 6. Hearing/Sight | | | | | | | |
| 7. Primary Doctor Contact: | | | | | | | | | | | | | | | 8. Insurance | | | | | | | 9.Allergies |
| **Status Of The Following** | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | |  |  |  | | | |  |  |  | | | | |  |  |  | |
|  | | *Ambulating* | | | |  |  | *Bathing* | | | |  |  | *Dressing/Grooming* | | | | |  |  | *Eating* | |
|  | | Independent | | | |  |  | Independent | | | |  |  | Independent | | | | |  |  | Independent | |
|  | | Needs Supervision | | | |  |  | Needs Supervision | | | |  |  | Needs Supervision | | | | |  |  | Needs Supervision | |
|  | | Total Care | | | |  |  | Needs Assistance | | | |  |  | Needs Assistance | | | | |  |  | Needs Spoon Fed | |
|  | | Bedridden | | | |  |  | Total Help | | | |  |  | Bedridden | | | | |  |  | Tube Feeding | |
|  | |  | | | |  |  |  | | | |  |  |  | | | | |  |  |  | |
|  | | *Transferring* | | | |  |  | *Toileting* | | | |  |  | *Medications* | | | | |  |  | *Cognition* | |
|  | | Independent | | | |  |  | Independent | | | |  |  | Independent | | | | |  |  | Always Alert | |
|  | | Needs Supervision | | | |  |  | Needs some Help | | | |  |  | Needs Supervision | | | | |  |  | Sometimes Alert | |
|  | | Needs Assistance | | | |  |  | Incontinent | | | |  |  | Needs Assistance | | | | |  |  | Early Dementia | |
|  | | Hoyer | | | |  |  | Catheter Care | | | |  |  | Total Help | | | | |  |  | Advanced Dementia | |
|  | |  | | | |  |  |  | | | |  |  |  | | | | |  |  |  | |
| Other/Notes: | | | | | | | | | | | | | | | | | | | | | | |
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| **Mobility Assistance** | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  |  |  | | | |  |  |  | | | | |  |  |  | | | | |
|  | Wheelchair | |  |  | Walker | | | |  |  | Cane | | | | |  |  | Motorized Chair | | | | |
|  |  | |  |  |  | | | |  |  |  | | | | |  |  |  | | | | |
| **Do You Have Any Of The Following Items?** | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  |  |  | | | |  |  |  | | | | |  |  |  | | | | |
|  | Oxygen | |  |  | Hospital Bed | | | |  |  | Alcohol Drinker | | | | |  |  | Pets | | | | |
|  |  | |  |  |  | | | |  |  |  | | | | |  |  |  | | | | |

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| **Facility Preferences** | |
| 1. Location | 2. Assisted Living / Memory Care / Independent Living |
| 3. Budget/ Finances | 4. Style of Room Desired (Studio, 1 or 2 Bedroom) |
| 5. Desired Amenities | |
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| 6. Desired Times/Dates to Tour | |
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| 7. Facilities to Tour: | |
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| **Tours Scheduled** |
| 1) |
| 2) |
| 3) |

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| **Notes** |
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