

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

ADCAPS

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

<b>I. Physical Assessment (Nursing)</b>
---------------------------------------------

Date																				
Height																				
Weight																				
Blood Pressure																				
Heart Rate																				
Initials																				

Instructions: In each Category enter the number(s) which apply. If nothing applies enter 0.

Physical Assessment																				
<u>Cardiac System</u>	Date																			
1. Congestive Heart Failure	Code																			
2. Myocardial Infarction																				
3. Arrhythmia																				
4. Coronary Artery Disease																				
5. Other																				
<u>Vascular System</u>																				
1. Peripheral vascular disease																				
2. Arterio/Atherosclerosis																				
3. Hyper/Hypotension																				
4. CVA/TIA																				
5. Other																				
<u>Respiratory System</u>																				
1. Chronic Obstructive Pulmonary Disease																				
2. Pneumonia																				
3. Upper Respiratory Infections																				
4. Lung Cancer																				
5. Tuberculosis																				
6. Other																				
<u>Neurological System</u>																				
1. Parkinson's Disease																				
2. Alzheimer's Disease/Dementia																				
3. Retardation																				
4. Seizure Disorder																				
5. Other																				
<b>Initials</b>																				

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

ID #: \_\_\_\_\_

Physical Assessment																				
<b>Gastrointestinal System</b> 1. Esophagus/Stomach Disease 2. Intestinal/Rectal Disease 3. Liver/Gallbladder Disease 4. Pancreatic Disease 5. Other	Date																			
	Code																			
<b>Integumentary System</b> 1. Ulcers (stasis, pressure sores, peripheral vascular) 2. Skin Cancer 3. Dermatitis 4. Infectious processes 5. Other																				
<b>Musculo-Skeletal System</b> 1. Arthritis 2. Osteoporosis 3. Amputations 4. Skeletal Deformities/contractures 5. Other																				
<b>Urinary System</b> 1. Urinary Tract Infection 2. Renal Failure 3. Kidney Stones 4. Urinary Retention 5. Other																				
Initials																				

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

Physical Assessment	
<b>Reproductive System</b> 1. Benign Prostatic Hypertrophy 2. Menses Issue (Menopause/ Menstruation) 3. Cancer (breast, uterus, ovaries, prostate) 4. Sexually Transmitted Diseases 5. Other	Date
	Code
<b>Endocrine System</b> 1. Type I Diabetes (IDDM) 2. Type II Diabetes 3. Adrenal/Pituitary Disorders 4. Thyroid Disease, Hypo/Hyper 5. Other	

**II. Functional Assessment/F.A.  
(Nursing)**

F.A./Communication Patterns	
<b>Hearing</b> 1. Hears adequately 2. Minimal difficulty 3. Hears in special situations only 4. Highly impaired 5. Other (eg. aids present/used)	
Initials	

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

F.A./Functional Assessment	
<u>Vision</u> 1. Sees adequately 2. Visual problems present (blurred vision; visual field deficit peripheral vision) 3. Disease process 4. Blindness 5. Other	Data
	Code
<u>Mode of Expression</u> 1. Verbal communication 2. Sign language/Braille 3. Signs/gestures/sounds 4. Written messages/communication board 5. Other	
<u>Speech Clarity</u> 1. Normal/clear/low 2. Slurred/difficult 3. Mumbled 4. Aphasia 5. Absence of spoken words 6. Other	
Initials	

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

ID #: \_\_\_\_\_

F.A./Communication Patterns																				
<b><u>Making Self Understood</u></b>  1. Understood 2. Usually understood 3. Rarely/never understood 4. Non-English speaking 5. Language barriers (e.g. word salad, gibberish) 6. Other	Date																			
	Code																			
<b><u>Ability to Understand Others</u></b>  1. Understands 2. Usually understands 3. Sometimes understands 4. Rarely/never understands 5. Other																				
<b>F.A./Continance</b>																				
<b><u>Status/Bladder</u></b>  1. Continent 2. Usually continent (occasional incontinence) 3. Incontinent 25% 4. Incontinent 50-75% 5. Incontinent																				
<b><u>Continance Status/Bowel</u></b>  1. Continent 2. Usually continent/ occasional incontinence 3. Incontinent 25% 4. Incontinent 50%-75% 5. Incontinent																				
<b>Initials</b>																				

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

<b>F.A./Continenence</b>	
<b>Bowel/Bladder Appliances/ Programs/Products</b> 1. Scheduled toileting 2. Wears protective pads/briefs 3. Catheter 4. Ostomy	Date
	Code

**III. Mobility Assessment (Nursing)**

<b>Mobility</b>	
<b>Neuromuscular Limitations</b> 1. Impaired/Limited ROM 2. Weakness 3. Impaired gait/balance 4. Paralysis	
<b>Psychomotor Problems</b> 1. Inconsistent use of assistive device 2. Cannot walk on uneven surfaces/stairs 3. Requires cueing 4. History of falls	
<b>Ambulation Ability</b> 1. Independent 2. Independent with assistive device (specify) 3. Supervision/Cueing needed 4. Physical assistance of one person needed 5. Physical assistance of more than one person needed	
<b>Initials</b>	

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

<b>Mobility</b>												
<u>Transfer Ability</u> 1. Independent 2. Independent with assistive device (specify) 3. Supervision/Cueing needed 4. Physical assistance of one person needed 5. Physical assistance of more than one person needed	Date											
	Code											

**IV. ADL Assessment (Nursing)**

<b>ADL Evaluation</b>												
<u>Grooming</u> 1. Independent 2. Set-up help only 3. Supervision/cueing needed 4. (Some) physical assistance required 5. Dependent	Date											
	Code											
<u>Dressing</u> 1. Independent 2. Set-up help only 3. Supervision/cueing needed 4. (Some) physical assistance required 5. Dependent												
<u>Bathing</u> 1. Independent (with/without assistive devices) 2. Set-up help only 3. Supervision/cueing needed 4. (Some) physical assistance needed 5. Dependent												
<b>Initials</b>												

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

ID #: \_\_\_\_\_

ADL													
<u>Toileting</u> 1. Independent 2. Independent, but requires reminding/cueing 3. Supervision 4. (Some) physical assistance required 5. Dependent	Date												
	Code												
<u>Eating/Feeding</u> 1. Independent 2. Set up help only 3. Supervision/cueing needed 4. (Some) physical assistance required 5. Dependent (needs to be fed)													
Initials													

**V. Medication Management (Nursing)**

MEDICATION ALLERGIES: \_\_\_\_\_

Medication Management													
<u>Staff Involvement in Medication Process</u> 1. None, no meds prescribed/taken at center 2. None, participant self medicates 3. Staff need to administer medication 4. Staff needed for verbal cueing, supervision, verification 5. Staff needed for education, special medication training	Date												
	Code												
Initials													

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

**VI. Therapies  
(Nursing)**

Therapy													
<u>Participation</u> 1. Physical Therapy 2. Speech Therapy 3. Occupational Therapy 4. Behavioral Health Therapy 5. Other	Date												
	Code												
Initials													

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

**VII. Nutritional Assessment  
(Nursing)**

Nutrition													
<b>Diet</b> 1. No restriction/ modification 2. Special diet (specify) 3. Finely chopped/pureed 4. Tube feeding 5. Other	Date												
	Code												
<b>Appetite (typical)</b> 1. Excellent - eats 100% of meal 2. Good - eats 75% or more of meal 3. Fair - eats 50% or more of meal 4. Poor- eats 25% of meal 5. Eats nothing, takes only fluids													
<b>Mouth/Oral Health</b> 1. Dental caries 2. Missing/broken teeth 3. Lesions/tumors/ ulcerations/fissures 4. S/S of inflammation/ infection 5. Other													
<b>Nutritional Issues</b> 1. Social issues (e.g. requires solitary eating, company, special situation) 2. Feeding issues (e.g. requires adaptive equipment, thickener in food, other) 3. Food allergies/ intolerances 4. Compliance with diet 5. Other													
<b>Initials</b>													

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

Nutrition	
<u>Eating Problems</u> 1. Chokes/swallowing difficulty/ gagging 2. Holds food in mouth 3. Chewing problems 4. Other (e.g. pica [eating unnatural articles as food] takes other's food, altered taste)	Date
	Code
Initials	



Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

**IX. Home Management Assessment  
 (Social Work)**

**Initial Assessment:** Complete to the degree possible within the first 30 days.  
**Re-Assessments:** At a minimum update annually or more frequently as needed.

<b>Home Management</b>												
<u><b>Meal preparation</b></u> 1. Independent 2. With caregiver assistance 3. The caregiver 4. Unknown/cannot evaluate	<small>Date</small>											
	<small>Code</small>											
<u><b>Transportation Needs</b></u> 1. Independent 2. With caregiver assistance 3. The caregiver 4. Center provides transportation												
<u><b>Personal Laundry</b></u> 1. Independent 2. With caregiver assistance 3. The caregiver 4. Unknown/cannot evaluate												
<u><b>Light Household Chores</b></u> 1. Independent 2. With caregiver assistance 3. The caregiver 4. Unknown/cannot evaluate												
<u><b>Telephone Use</b></u> 1. Independent 2. With caregiver assistance 3. The caregiver 4. Unknown/cannot evaluate												
<b>Initials</b>												

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

**X. Mental/Behavioral Assessment  
 (Social Work)**

<b>Mental/Behavioral</b>												
<p style="text-align: center;"><u>Orientation</u></p> <p>1. Oriented x 3 (time, place, person)            2. Oriented x 2 (specify)            3. Oriented x 1 (specify)            4. Disoriented.            5. Unable to assess/unknown</p>	Date											
	Code											
<p style="text-align: center;"><u>Cognition</u></p> <p>(ability to act/react based on awareness, perception understanding, familiarity, knowledge)</p> <p>1. Independent thinking, intact            2. Prompting required in stressful/unfamiliar situations            3. Consistent cueing required            4. Requires assistance to process routine information            5. Dependent, due to disorientation, delirium, dementia/ mental age/illness</p>												
<p style="text-align: center;"><u>Thought Processes/Decision-making Ability/Judgement</u></p> <p>1. Independent, decisions consistent/reasonable            2. Independent, but consistency varies with situation            3. Cueing required for decision making            4. Supervision/assistance required/decisions poor            5. Unknown, rarely makes/never made decisions</p>												
<b>Initials</b>												

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

Mental/Behavioral													
<u>Cognitive Changes</u> (noted since last evaluation) 1. No change 2. Improved status 3. Deteriorated status 4. Unknown, unable to evaluate	Date												
	Code												
<u>Social Interaction</u> 1. Initiates conversation with others 2. Responds appropriately when others talk 3. Some inappropriate responses or minimal response to others 4. Constantly inappropriate or no response to others 5. Other													
<u>Indicators of Disordered Thinking</u> 1. None 2. Easily sidetracked/distracted 3. Confusion 4. Periods of altered perception (delusions, hallucinations, paranoia) 5. Other													
<u>Indications of Confusion (reported/observed)</u> 1. None 2. In new or complex situations only 3. During day or evening but not constantly 4. Constantly 5. Unknown/Unable to evaluate													
Initials													

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

Mental/ Behavioral															
<u>Memory</u> 1. Memory intact 2. Short term memory deficit 3. Long term memory deficit 4. Recognition memory deficit 5. Unknown/unable to assess	Date														
	Code														
<u>Behavioral Challenges (requiring staff intervention)</u> 1. Abusive/combatative behavior, verbal, physical 2. Socially inappropriate/disruptive/infantile 3. Wandering 4. Self-mutilating behavior 5. Other															
Initials															

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

**Clinical Depression Assessment (Optional)**  
**(Social Work/Nursing)**

- Instructions:**
1. Consider these Anxiety-Depression Related Symptoms.
  2. Then evaluate their frequency according to the scale below.
  3. If more than **3 behaviors** can be identified as occurring consistently discuss assessment findings at next team meeting and consider psychiatric referral.
  4. Document the behaviors noted under comments.

**Mood/Affect Changes**

Sad, flat, empty, hopeless, tearful, expressions of impending doom, unrealistic fears

**Psychomotor Retardation/Agitation**

Periods of lethargy, sluggishness, staring into space, hyperactivity, restlessness, fidgeting, picking, repetitive physical moments, accelerated speech, persistent questioning/attention getting behaviors

**Significant Weight Loss**

Change of 5% in one month

Noticeable decrease/increase of appetite nearly every day

**Fatigue/Loss of Energy**

**Insomnia/Hypersomnia**

**Diminished Interest/Pleasure**

**Feelings of Worthlessness/Inappropriate guilt**

Statements of self deprecation

**Cognitive Changes**

Diminished ability to think, concentrate, make decisions

**Recurrent Thoughts of Death**

Suicide ideation, suicide attempt, specific suicide plan

Clinical Depression												
<p><b><u>Frequency of Anxiety/Depression - related behaviors</u></b></p> <p>1. Not at all</p> <p>2. Frequent, but not consistent</p> <p>3. Consistently observed and/or represents change from previous function</p>	Date											
	Code											
	<b>Initials</b>											

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

ID #: \_\_\_\_\_

**XI. Psychosocial Assessment  
(Social Work)**

Psychosocial												
<b><u>Evidence of Family/Caregiver Involvement/Support</u></b> 1. Yes 2. No 3. Other	Date											
	Code											
<b><u>Caregiving Appropriate to Participant's Needs</u></b> 1. Yes 2. No 3. Other												
<b><u>Adjusted to Present Residence</u></b> 1. Yes 2. No 3. Other												
<b><u>Caregiving Concerns (physical, emotional, social, spiritual, financial)</u></b> 1. Not currently 2. Unknown 3. Moderate 4. Severe												
<b><u>Utilization of Community Resources</u></b> 1. Financial 2. Medical 3. Recreational/Social 4. Spiritual/Religious 5. Guardianship/Legal 6. Other												
<b>Initials</b>												

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

**XII. Activities Assessment  
 (Activities)**

Activities													
<u>Attention/Motivation</u> 1. Self-motivated - finishes tasks 2. Needs assistance, but will finish tasks 3. Low attention span, loses interest in tasks 4. Observes only 5. Disinterested	Date												
	Code												
<u>Activity Enjoyment</u> 1. Very high, participates with interest and enthusiasm 2. High, participates on own in routine/ superficial manner 3. Moderate, participates reluctantly or only after urging, shows little pleasure 4. Low, no participation, looks bored/unhappy, may wander or sleep 5. Other													
<u>Status of Program Participation</u> 1. Active/Independent participation 2. Participates with assistance (specify) 3. Needs small group or one to one activities 4. Participation varies with 5. Other													
Initials													

Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_

<u>Frequency of Program Participation</u>	
1. Always 2. Usually 3. Sometimes 4. Varies, based on.... 5. Other	Date
	Code
<u>Quality of Participation</u> 1. Active in a variety of tasks, cooperates with group activity 2. Limits task involvement, prefers more solitary activity or 1:1 interaction 3. Passive, requires cueing/ encouragement for program participation. 4. Observer only 5. Other (e.g. disinterested, isolates self, etc.)	
Initials	