

RESTORATIVE NURSING ASSESSMENT

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Resident's Name: _____ Date of Assessment: _____

Reason for Screening: _____

Diagnoses: _____

Prior level of functioning: _____

Name of Current Medications: _____	Potential side effects affecting gait/balance
_____	Yes/No
_____	Yes/No
_____	Yes/No
_____	Yes/No
_____	Yes/No
_____	Yes/No
_____	Yes/No
_____	Yes/No
_____	Yes/No
_____	Yes/No
_____	Yes/No

Has the resident received skilled therapy in the past? Yes ___ No ___
If yes, which disciplines? _____ Dates of last service _____
Has the resident received restorative nursing services in the past? Yes ___ No ___
If yes, dates of service _____ Describe plan _____

MUSCULOSKELETAL FUNCTIONAL STATUS

Gait: steady ___; bedfast ___; hemiplegia: rt ___ lt ___; quadriplegia ___; paraplegia ___;
Poor shoulder/arm movement: rt ___ lt ___; poor hand dexterity: rt ___ lt ___; poor leg movement:
Rt ___ lt ___; unsteady gait ___; poor trunk movement ___; foot drop ___; amputation: ___ site: ___

Contractures: a. none ___	Weight bearing:
Site	1. Full wt. bearing ___
Right	2. Partial wt. bearing ___
Left	3. Non wt. bearing ___
b. face/neck	_____
c. shoulder/elbow	_____
d. hand/wrist	_____
e. hip/knee	_____
f. foot/ankles	_____

Congenital abnormalities: _____

Current fractures: _____ Date of fracture _____

Check any current conditions: joint stiffness ___; muscle weakness ___; muscle cramps ___;
joint swelling ___; other _____

Has resident had falls within past month? Yes ___ No ___

Has resident had falls within past 6 months? Yes ___ No ___ If yes, specify any injuries sustained: _____

Mobility Assistive Devices Used: Ambulatory without device ___; cane ___; walker ___;
Brace/prostheses ___; walks behind w/c ___; wheelchair self-propelled ___; wheelchair/unable to self-
Propel ___; gerichair ___; gait belt needed ___; mechanical lift needed ___; trapeze ___; hand-rolls/cones ___;
Brace ___; stands to transfer ___; requires lifted to transfer ___