NURSING HOME DOCUMENTATION FORM

Patient: _____ Room: _____ Date: _____

Code Status: ☐ Full ☐ DNR / DNI ☐ Other: _____

Family Contact: _____ POA: _____

Admit Date: _____ Level of Care: _____

Previous Facility: _____

PMH: ☐ HTN ☐ HLP ☐ CAD ☐ DM ☐ CHF ☐ COPD
☐ CVA ☐ Dementia

_____

_____

_____

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_____

Medications Start Date

_____

_____

_____

All: ☐ NKDA	
VACC	Date
Td	
Zoster	
Pneu	
Flu	

_____

_____

_____

_____

_____

_____

Social

Current Activities: _____

Former Occupation: _____

Living Relative/Friends: _____

CC / New Concerns

_____

_____

Signature: _____

ROS / Geriatric Syndromes		
Function (activities of daily living) *I = Independent S = With Supervision* *A = Moderate Assist X = Max Assist*		
	Bathing	
	Dressing	
	Toileting	
	Transferring	
	Feeding	
	Continence	

Cognition:
Mood: *(depression, anx, behav)*
Sensory: *(vision, hearing)*
Falls / Gait:
Nutrition:
Exercise:

Exam Pain Scale: _____ Wt: ↑ / ↓ _____

Gen: _____

HEENT: _____

_____

	HR	BP

_____ Dentition: _____

Pulm: _____

CV: _____

Abd: _____ **Rect:** _____

EXT & MS: _____

Skin: _____

Neuro: _____

Sit → Stand: _____ Get-up & go: _____ Grip strength: _____

PSY: MMSE: _____ GDS: _____ CSDD: _____

_____

Other Disciplines / Care Plan

_____

_____

_____

Assessment & Plan

_____

_____

_____

_____

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.