

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

Medications _____ Start Date _____

All: <input type="checkbox"/> 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>I = Independent S = With Supervision</i> <i>A = Moderate Assist X = Max Assist</i>	
Bathing	
Dressing	
Toileting	
Transferring	
Feeding	
Continence	

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

Exam Pain Scale: _____ Wt: \uparrow/\downarrow _____

Gen: _____

HEENT: _____

	HR	BP
\uparrow		
\downarrow		
\rightarrow		

_____ Dentition: _____

Pulm: _____

CV: _____

Abd: _____ Rect: _____

EXT & MS: _____

Skin: _____

Neuro: _____

Sit \rightarrow Stand: _____ Get-up & go: _____ Grip strength: _____

PSY: MMSE: _____ GDS: _____ CSDD: _____

Other Disciplines / Care Plan

Assessment & Plan



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

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