

Level of Care Assessment

Patient information	
Patient name:	
Date of birth:	
Address:	
Contact information:	
Emergency contact name:	
Relationship:	
Emergency contact information:	
Vision function with correction, if needed (check one):	
Full vision	Difficulty at level of print
Difficulty with obstacles	Blind
Others:	
Hearing function with correction, if needed (check one):	
Full hearing	Difficulty at level of communication
Difficulty with alarm sounds	Deaf
Others:	
Communication - expressive (check all that apply):	
Speech easily understood	Speech difficult to understand
Uses sign language	Uses gestures and/or some signs
Uses alternative communication device	Has no functional communication
Comments:	
Communication - receptive (check all that apply):	
Other's speech easily understood	Other's speech difficult to understand
Can understand sign language	Can understand gestures and/or some signs
Can understand others using alternative communication device	Has no functional understanding of communication
Comments:	

Activities of daily living (ADLs)			
Activity	Independent	Needs assistance	Completely dependent
Personal hygiene and bathing			
Dressing			
Toileting			
Continence			
Mobility/transferring			
Feeding			
Notes:			
Instrumental activities of daily living (IADLs)			
Activity	Independent	Needs assistance	Completely dependent
Managing finances			
Meal preparation			
Transportation (driving or using public transport)			
Shopping			
Housekeeping			
Medication management			
Notes:			
Health issues/medical needs			
Current medical conditions			
Medications taken			

Specialized medical care requirements (check all that apply):	
IV medications	Catheter care
Injections	Wound care
Oxygen therapy	Feeding tube
Physical therapy	Others:
Cognitive function	
Mental status	
Alert and oriented x4 (person, place, time, situation)	Mild confusion
Moderate confusion	Severe confusion
Decision-making ability	
Independent	Needs support with complex decisions
Needs support with basic decisions	Unable to make decisions
Memory	
<i>Recent memory:</i>	
Intact	Mild impairment
Moderate impairment	Severe impairment
<i>Long-term memory:</i>	
Intact	Mild impairment
Moderate impairment	Severe impairment
Behavioral and emotional assessment	
Check all that apply:	
Wandering	Getting lost in familiar places
Unsafe cooking/leaving stove on	Unsafe medication management
Falls risk	Resistance to care
Social withdrawal	
Notes on emotional well-being	
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Support system	
Who assists the patient with their care? (check all that apply):	
Family members	Friends
Professional caregivers	None
Assessment summary	
Level of care recommendation	
Independent living	Assisted living
Skilled nursing care	Other:
Recommended services/interventions	
Additional notes	
Assessor's name:	
Title/position:	
Date of assessment:	
Signature:	