RESIDENT FUNCTIONAL CAPACITY SCREEN

I. Identification Information

A. Resident Name

First: _____ MI: _____

Last: _____

B. Date of Assessment

Month Day Year

C. Primary Reason for Screen: ☐

1. Admission
2. Significant Change
3. Annual

D. Gender: ☐ 1. Male 2. Female

E. Birthdate:

Month Day Year

II. Functional Screen

Enter the code in the box to indicate resident's level of self-performance at the time of the functional screen.

0. Independent
1. Supervision needed
2. Physical assistance needed
3. Unable to perform

A. Activities of Daily Living

1. Bathing ☐
2. Dressing ☐
3. Toileting ☐
4. Transfer ☐
5. Walking, Mobility ☐
6. Eating ☐

B. Instrumental Activities of Daily Living

1. Meal Preparation ☐
2. Shopping ☐
3. Money Management ☐
4. Transportation ☐
5. Use of Telephone ☐
6. Laundry, Housekeeping ☐
7. Management of Medications ☐
8. Management of Medical Treatments ☐

C. Bladder Continence (code current performance for resident) ☐

0. Continent
1. Usually Continent
2. Occassionally Incontinent
3. Frequently Incontinent
4. Incontinent

D. Cognition - Memory, Recall (record results from exam in manual)

A. Short Term Memory ☐
B. Long Term Memory ☐
C. Memory/Recall ☐
D. Decision-Making ☐

Total Score ☐

E. Communication

1. Expresses information content, however able ☐

0. Understandable
1. Usually understandable
2. Sometime understandable
3. Rarely or never understandable

2. Ability to understand others, verbal information, however able ☐

0. Understands
1. Usually Understands
2. Sometimes Understands
3. Rarely or Never Understands

III. Current or Recent Problems and Risks

Check all the current or recent problems and risks the resident has had.

1. Falls, Unsteadiness ☐
2. Impaired Vision ☐
3. Impaired Hearing ☐
4. Wandering ☐
5. Socially Inappropriate Disruptive Behavior ☐
6. Impaired Decision-Making ☐
7. None ☐

IV. Mobility Appliance/Devices

Check all that apply.

a. Cane, Walker, Crutch ☐
b. Brace, Prothesis ☐
c. Wheelchair ☐
d. Mechanical Lift ☐
e. None of the Above ☐

V. ADL/IADL Rehab Potential

Check all that apply.

a. Resident believes self to be capable of increased independence in at least some ADL's and IADL's. ☐
b. Resident can perform task or activity but is very slow. ☐
c. Major difference in ADL and/or IADL functioning in mornings and evenings. ☐
d. Tires noticeably most days. ☐
e. Active avoidance of activity that resident is physically and cognitively capable of. ☐

VI. Medications

Name	Dosage	Route	Frequency

VII. Ordered Therapies and Treatments

VIII. Support

A. Primary person for legal and financial matters (check all that apply)

1. Self ☐
2. Spouse ☐
3. Son/Daughter ☐
4. Other Relative ☐
5. Guardian ☐
6. Durable Power of Attorney for Health Care ☐
7. Durable Power of Attorney/Power of Attorney ☐
8. Other Legal Oversignt ☐
9. Friend ☐
10. Other:_____ ☐

B. Primary person who manages care/financial matters, if other than client.

Name: _____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

IX. Comments

X. Participation in Screen

Resident	0 No	1 Yes	☐
Family	0 No	1 Yes	☐
Other	0 No	1 Yes	☐

XI. Signature of those completing the screen.

Signature: Date:

_____ _____

_____ _____

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