Resident Care Assignment Sheet

	Resident Initials ______________________________ **Room #**_____________________ **Bed**____________ Alert____ Confused at times____ Dementia____ Weak/paralyzed on Right ____ Left____ Paraplegia____ Quadriplegia____
BATHING	Independent____Assist____ Partial____ Shower____ Bed Bath____
TOILETING	Independent____ Assist____Incontinent Urine ____ Incontinent bowel____ Brief Color/Size
DRESSING	Independent____Assist____ Dependent____
FOOTWEAR	Socks____ TED Hose____ No Socks____ Gym Shoes____ Padded Foot Protector____ Other____
HAIR CARE	Independent____Assist____ Dependent____ Beauty Salon____
ORAL HYGIENE	Independent____Assist____ Dependent____ Dentures (upper/lower) ____
HEARING	Normal____ Some Loss____ Hearing Aid____
VISION	Normal____ Eyeglasses____ Partial Blind____ Total Blind____
SPEECH	Normal____Slow____ Dysphasia____ Unable to Speak____
AMBULATION	Independent____ Cane____ Walker____ W/C____ Bed Rest____
TRANSFER	Independent____ Assist x____ with Gaitbelt ____ Hoyer lift____ Transfer Board____ Special Instructions:
DIET	Independent____ Set-up____ Partial Feed____ Total Feed____ Regular____ NAS (no added salt) ____ Low Fat____ NCS (no concentrated sugar – diabetic) ____ Pureed____ Thick Liquids____ Other
SKIN CARE	Lotion____ TurnQ2H____ Out of w/c Q2H____ Pressure ulcer location__________________________________ None____ Skin tear location____None____ Rash location None
ISOLATION	YES____ NO____ If yes, name of infection:
Other Instructions:	
YOUR INITIALS	____