Harmony Healthcare International (HHI)
ADL Resident Assessment Flow Sheet

Last Name:	First Name:	M.I.:	Resident ID:	Sex:	Month:	Year:
Room #:	Bed #:	Unit:	Physician:	Facility:	Admission Date:	

0 = Does Not Apply			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Bed Mobility **A. ADL Self Performance** 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence **B. ADL Support Provided** 1 = 1 assist 2 = 2 assist	N	A																															
		B																															
	D	A																															
		B																															
	E	A																															
		B																															
Transfer **A. ADL Self Performance** 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence **B. ADL Support Provided** 1 = 1 assist 2 = 2 assist	N	A																															
		B																															
	D	A																															
		B																															
	E	A																															
		B																															
Toilet Use **A. ADL Self Performance** 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence **B. ADL Support Provided** 1 = 1 assist 2 = 2 assist	N	A																															
		B																															
	D	A																															
		B																															
	E	A																															
		B																															
Ambulation **A. ADL Self Performance** 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence **B. ADL Support Provided** 1 = 1 assist 2 = 2 assist	N	A																															
		B																															
	D	A																															
		B																															
	E	A																															
		B																															
Locomotion On Unit 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence	N																																
	D																																
	E																																
Locomotion Off Unit 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence	N																																
	D																																
	E																																

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430 Boston Street, Suite 104, Topsfield, MA 01983 • Tel: 978-887-8919 • Fax: 978-887-3738
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0 = Does Not Apply		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Eating 1. Independent 2. Continual Supervision 1:8 ratio 3. Physically Assisted 4. Total Dependence 5. Tube Feed Only 6. Tube Feed and PO Assist 7. Tube Feed and Total Dependence	N																															
	D																															
	E																															
Grooming Mouth Care, Hair, Nails, Shave 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence	N																															
	D																															
	E																															
Bathing 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence	N																															
	D																															
	E																															
Dressing 1. Independent 2. Continual Supervision 3. Non-Weight Bearing Assist (CTG, Light Touching) 4. Weight-Bearing Assist (Min, Mod, Max) 5. Total Dependence	N																															
	D																															
	E																															
Bladder Function 1. Continent 2. Incontinent 3.Toileted Ahead of Need 4. Indwelling Catheter	N																															
	D																															
	E																															
Bowel Function 1. Continent 2. Incontinent 3.Toileted Ahead of Need 4. Colostomy/Ileostomy	N																															
	D																															
	E																															
Pressure Ulcer Prevention 1. Product:_____ Frequency:_____ Site:_____ 2. Heel Protectors 3. Elbow Protectors 4. Hand roll 5. Diabetic foot care	N																															
	D																															
	E																															
Nursing Assistant Initials	N																															
	D																															
	E																															

Signature	Initials	Signature	Initials	Signature	Initials	Signature	Initials
Signature	**Initials**	**Signature**	**Initials**	**Signature**	**Initials**	**Signature**	**Initials**

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ADL Resident Assessment Flow Sheet
Positioning Sheet

0 = Does Not Apply		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Positioning Select one letter and one number: 1 = 1 assist 2 = 2 assist L = Left Side R = Right side B = Back C = Weight Shift	12AM																															
	2AM																															
	4AM																															
	6AM																															
	8AM																															
	10AM																															
	12PM																															
	2PM																															
	4PM																															
	6PM																															
	8PM																															
	10PM																															
Nursing Assistant Initials	N																															
	D																															
	E																															

Signature	Initials	Signature	Initials	Signature	Initials	Signature	Initials
Signature	**Initials**	**Signature**	**Initials**	**Signature**	**Initials**	**Signature**	**Initials**

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