



Name: _____
MR#: _____ RM# _____

To be completed for: _____ (mm/dd/yy)

SHIFT	7-3				3-11				11-7			
	Self	1HH	2 HH or more	Does not do this	Self	1HH	2 HH or more	Does not do this	Self	1HH	2 HH or more	Does not do this
TYPE OF ASSISTANCE												
<i>Activities (Mark off each item with a ✓)</i>												
<i>My Resident:</i>												
1. Gets into or out of bed												
2. Positions him/herself correctly in bed												
3. Rolls from side to side in the bed												
4. Sits up from lying down												
5. Moves to or from the bed, chair, wheelchair, or standing position (don't count the bath and toilet here)												
6. Is able to eat												
7. Manages his/her food (open, cuts up, butter bread etc)												
8. Manages lifting a fork, knife and/or spoon or a cup or glass												
9. Needs reminding to finish the meal												
10. Uses the bathroom or uses a commode or urinal or bedpan.												
11. Transfers on and off the toilet, commode and/or bedpan.												
12. Manages taking clothes or brief off and/or pulling them up and adjusting them after going to the bathroom, or using the commode or bedpan												
13. Manages wiping him/herself and/or washing hands after going to the bathroom												
14. Manages his/her own ostomy or catheter												

Day C.N.A. Signature	Evening C.N.A. Signature	Night C.N.A. Signature



Name: _____
MR#: _____ RM# _____

To be completed for: _____ (mm/dd/yy)

SHIFT	7-3	3-11	11-7
MOOD (Mark each item as appropriate with a check ✓)			
My Resident:			
1. Is easily distracted-can't concentrate			
2. Moves very slowly			
3. Is really fidgety or can't sit still or lie still			
4. Doesn't want to do things			
5. Doesn't like to do what he/she used to do			
6. Feels sad or down or hopeless or cries all the time			
7. Sleeps all the time			
8. Can't fall asleep			
9. Doesn't have energy that he/she used to have			
10. Doesn't eat as well as he/she used to			
11. Eats all the time and didn't used to			
12. Says he/she feels bad and/or has let his/her family down			
13. Says he/she would be better off DEAD			
14. Says he/she would like to hurt him/herself			

SHIFT	7-3	3-11	11-7
BEHAVIOR (Mark each item as appropriate check ✓)			
My Resident:			
1. Pushes, hits, kicks, scratches other			
2. Threatens, curses /screams at others			
3. Hits or scratches self, rummaging, pacing			
4. Takes off clothes in public, smears feces, engages in public sexual acts			
5. Makes disruptive sounds, screams			
6. Rejects taking medication, lab work, x-rays, Rehab, participating in activities			
7. Needs help with ADL BUT REJECTS IT.			
8. Wanders and bothers others			
9. Wanders and does not bother others			
10. Believes things that aren't true (ex: "picking up their child from school today, looking for a deceased loved one", etc)			

Day CNA Signature	Evening CNA Signature	Nights CNA Signature