

## HRST DATA WORKSHEET

<b>NAME:</b>	Assessor Name:
Birth date:	SS#:
Admit. Date:	Assessment Date:
Address:	Admitted From:
Admitting DX :	Address:

Comments:

A

### Routine Medications/Treatments

Drug Name	Dosage	Indications	Drug Name	Dosage	Indications
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

### Activities of Daily Living

A. Eating:      Independent:      Supervised:      People:      G/J Tube

Comments:

B. Ambulation:      Independent:      Supervised:      People:      Wheelchair:

Comments:

C. Transfers:      Independent:      Supervised:      People:      Equipment:

Comments:

D. Toileting:      Independent:      L. Supervision:      Incontinent      Bladder:      Appliance:  
Bowel:

Comments:

E. Day Program:      Disability:      Does      Does not:      Prevent participation

Comments:

### Behaviors

F. Self-Abuse:      No:      Yes:      Incidents per Mo:      Injuries:

Comments:

G. Aggression:      No:      Yes:      Incidents per Mo:      Injuries:

Comments:

H. Use of Physical Restraints:      No:      Yes:      Frequency:      Device(s)

Comments:

I. Emergency Drugs:      No:      Yes:      Date(s):      Drug(s)

Comments:

J. Psychotropic Drugs:      No:      Yes:      Drug(s)

Comments:

### Physiological

K. Gastrointestinal:      GI symptoms      DX:      Drug(s)

Frequency of Symptoms      Hx of GI bleed:      Date(s)

Hx of Obstruction      Date(s)      Hx of Gerd

Comments:

L. Seizures:	No:	Yes:	Type(s):	Date of Last S.:
Comments:				
N. Skin Breakdown:	No:	Yes:	Current Condition/Grade	
Hospitalizations:	No:	Yes:	Date(s):	
Comments:				
O. Bowel Functions:	No problems:	Dietary Management:	Diet & Supplements:	
Daily obs. Enemas, etc.		Date(s) Hospl		
Comments:				
P. Nutrition:	Ht.	Wt.	Wt Hx:	
Cond. Assoc. with			Lab Values:	
Nut. Instability:				
Comments:				
Q. Treatments:	No:	Type(s):		
Comments:				
R. Injuries:	No:	Type(s) & Date(s):		
Hospitalization(s) & Date(s):				
Comments:				
S. Falls:	No:	Yes:	Date(s):	
Hospitalization(s):				
Comments:				
<b>Frequency of Service</b>				
T. Prof. Health Care Services:	Frequency:	Emergency Ser.:	No:	Yes: Date(s):
Comments:				
U. ER visits:	No:	Yes:	Date(s):	
Resulted in Admission:	No:	Yes:	Date(s):	
Outcome(s)				
Comments:				
V. Hospital Admissions:	None:	Scheduled:	Date/Procedure(s):	
Acute Cond.:				
		Type(s):	Dates of ICU Admission(s)	
Outcome(s)				
Comments:				
<b>General Comments</b>				