

NIGHTINGALE HOUSE ASSISTED LIVING FACILITY

ENQUIRY ASSESSMENT FORM

Please fill in as much as you can. Thank You

A. Point of Contact / Guardian

- 1 Name _____ Cell # _____
- 2 Relation to potential Resident _____
- 3 Monthly Budget _____
- 4 Source of Payment: Private () Long term care insurance () Other ()
- 5 When do you want to Tour (will be confirmed) Day(s) _____ Time _____
- 6 How soon do you expect Resident to move _____

B. Potential Resident

- 1 Name _____ Age _____ cell# _____
- 2 Current Living situation: Rehab (), Home/ Independent (), Assisted Living ()
- 3 Mobility: Independent (), Cane (), Wheel-chair ()
- 4 Bathing assistance Needed _____
- 5 Toileting Assistance Needed _____
- 6 Medication Administration e.g. Insulin shots Needed _____
- 7 Memory Issues / diagnosis _____
- 8 Combative : Yes (), No ()
- 9 Wandering: Yes (), No ()