

**LIGHTHOUSE PROGRAM
RN Assessment, Cont.**

Service recipient Name: _____ **Date of Assessment:** _____

Describe service recipient's ability to perform the following Personal Care Tasks:

Grooming

Bathing

Dressing

Toileting

**LIGHTHOUSE PROGRAM
RN Assessment, Cont.**

Service recipient Name: _____ **Date of Assessment:** _____

Describe the service recipient's ability to perform the following Mobility Tasks:

Transferring

Walking

Turning/Repositioning

Describe the service recipient's ability to perform the following Nutritional Tasks:

Meal Preparation

**LIGHTHOUSE PROGRAM
RN Assessment, Cont.**

Service recipient Name: _____ **Date of Assessment:** _____

Describe the service recipient's ability to perform the following Nutritional Tasks, cont.:

Feeding and/or special dietary needs

Shopping

Describe the Service recipient's ability to perform the following Environmental Tasks:

Light Housecleaning

Dishwashing
