LIGHTHOUSE PROGRAM
RN Assessment

Service Recipient Name: _____

Date of Assessment: _____ **Date of Birth**: _____

Describe Service recipient's living conditions:

Narrative (include medical history, current diagnoses, medications, allergies, and current conditions):

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

LIGHTHOUSE PROGRAM
RN Assessment, Cont.

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

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

Making/Changing bed

Service recipient's laundry

Summary:

RN signature: _____ **Date:** _____