## LIGHTHOUSE PROGRAM RN Assessment

Service Recipient Name:	
Date of Assessment:	Date of Birth:
Describe Service recipient's livingconditions:	
Narrative (include medical history, current diagnoses,	medications, allergies, and current conditions):

Service recipient Name:	_Date of Assessment:	
Describe service recipient's ability to perform the following Personal Care Tasks:		
Grooming		
Bathing		
Dressing		
Toileting		

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 p	erform the following Nutritional Tasks:
MealPreparation	

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	

Service recipient Name:	Date of Assessment:
Describe the Service recipient's ability to perf	orm the following Environmental Tasks, cont.:
Making/Changingbed	
Service recipient's laundry	
Summary:	