Sample Nurse Aide Worksheet **Your Facility**

Name: _____ DOB: _____ Unit/Room: _____ Medical Record #: _____

Diagnosis: _____ Allergies: _____ DNR: Yes No Hospice/Comfort Care

Diet: _____ Feeding Status: Level of assist: Adaptive Feeding Equip: No Yes--List: _____

Has Swallowing Strategy Sheet: Y N Tube Feeder Y N Laundry: ☐ Done by family ☐ Done by VRM

GENERAL INFORMATION:

MENTAL STATUS
☐ confused ☐ alert
☐ forgetful ☐ oriented
☐ combative
☐ other:_____
☐ *see behavior care plan

COMMUNICATION
☐ does not speak ☐ clear
☐ speech unclear
☐ speaks foreign language
☐ other:_____

MOUTH CARE
☐ Own teeth
☐ Dentures U L
☐ Partials U L
☐ Independent
☐ Assist Level:_____
☐ Total Care
Instructions:

NAIL CARE
☐ Independent
☐ Done by: ☐ C.N.A. ☐ Nurse
☐ Do on shower/bath day

GLASSES
☐ None
☐ Wears Glasses for:
☐ Reading ☐ Always
Color/Shape:

Stored:

HEARING / HEARING AIDE
☐ HOH ☐ None
☐ Left ☐ Right
☐ Independent On/Off
☐ Assist needed
Stored:

Instructions:

OXYGEN USE:
☐ None ☐ Liters:_____
Instructions:

SMOKING:
☐ No ☐ Yes ☐ Independent
☐ Supervised

ADL'S

BATHING:
Upper Body:
☐ Indep ☐ Sup ☐ SBG ☐ CG
☐ Min ☐ Mod ☐ Max
☐ Assist x 2 ☐ Total
Lower Body:
☐ Indep ☐ Sup ☐ SBG ☐ CG
☐ Min ☐ Mod ☐ Max
☐ Assist x 2 ☐ Total

DRESSING:
Upper Body:
☐ Indep ☐ Sup ☐ SBG ☐ CG
☐ Min ☐ Mod ☐ Max
☐ Assist x 2 ☐ Total
Lower Body:
☐ Indep ☐ Sup ☐ SBG ☐ CG
☐ Min ☐ Mod ☐ Max
☐ Assist x 2 ☐ Total

GROOMING:
(wash face, comb hair)
☐ Indep ☐ Sup ☐ SBG ☐ CG
☐ Min ☐ Mod ☐ Max
☐ Assist x 2 ☐ Total

TOILETING SKILLS

TOILET TRANSFER (TO/FROM TOILET):
* = gait belt needed
☐ Indep ☐ Sup ☐ SBG ☐ CG*
☐ Assist x 1* ☐ Assist x 2*

☐ Standing Lift(circle): Encore Lumex
☐ Mechanical Lift: Tempo / Lumex
with assist of (circle) 2, 3, 4
☐ Does not transfer to toilet

TOILETING (CLOTHES AND HYGIENE):
CLOTHING MANAGEMENT:
☐ Indep ☐ Sup ☐ SBG ☐ CG
☐ Min ☐ Mod ☐ Max
☐ Assist x 2 ☐ Total
HYGIENE:
☐ Indep ☐ Sup ☐ SBG ☐ CG
☐ Min ☐ Mod ☐ Max
☐ Assist x 2 ☐ Total

TOILETING / OTHER:
☐ Timed toileting ☐ Bed pan
☐ Prompted Void ☐ Foley Cath
☐ Check and change ☐ Colostomy
☐ Urinal @ bedside
☐ Commode @ bedside

MOBILITY

BED MOBILITY:
☐ Indep ☐ Sup ☐ SBG ☐ CG
☐ Assist x 1 ☐ Assist x 2
☐ Dependent
☐ no rail
☐ rail: L R for mobility

IN/OOB TRANSFERS:
☐ Indep ☐ Sup ☐ SBG ☐ CG*
☐ Assist x 1* ☐ Assist x 2*
☐ Hand hold*: 1 or 2
☐ Standing Lift (circle):
Encore Lumex
☐ Mechanical Lift (circle):
Hoyer Tempo Lumex
with assist of (circle) 2, 3, 4

AMBULATION PROGRAM:
☐ Non Ambulatory
☐ Daily and prn ☐ Meals/prn
☐ To all unit destinations
☐ Other:

Device: ☐ wheeled walker
☐ other:

Assist: *= gait belt needed
☐ Indep
☐ Supervision
☐ Stand by guard
☐ *contact guard
☐ *Assist of 1
☐ *Assist of 2
☐ Needs wheelchair follow

Distance:

WHEELCHAIR MOBILITY:
☐ Independent
☐ Propels with: UE LE
☐ Distances: Long Short
☐ Dependent on others

RESTRAINTS /POSITIONING/ ALARMS

IN BED:
☐ concave mattress
☐ bed against wall L R
☐ 1/2 rail L R
☐ posey roll guards L R
☐ landing mat on floor L R
☐ HOB Elevated at all times
☐ Hip savers: size_____
on_____ off_____

OUT OF BED SEATING:
☐ Wheelchair: 16" 18" 20"
☐ Other:
☐ uses as main seating
☐ uses for off unit/transport only
☐ pedals on at all times
☐ pedals for transport only

☐ GerriChair or ☐ Lazy Boy
☐ feet up at all times unless 1:1
☐ Standard Chair (does not use w/c)
☐ Other(ie: power chair)

DEVICES IN CHAIR:
☐ Cushion Type: GEO Roho
Other:
☐ Bolsters / Laterals: L R
☐ Other

RESTRAINTS (release/reposition q2hrs)
☐ Seat belt: velcro clip
☐ Tray
☐ Other:

ALARMS: ***Check q shift per policy
Bed: ☐ none
☐ clip style ☐ pad style
Chair: ☐ none
☐ clip style ☐ pad style

ADL EQUIP/ OTHER

TRANSFER ON/OFF SHOWER CHAIR/TROLLEY

☐ Sup ☐ SBG ☐ CG* ☐ Assist x 1* ☐ Assist x 2
*= gait belt needed
☐ Standing Lift(circle): Encore Lumex
☐ Mechanical Lift:(circle) Hoyer Tempo Lumex
with assist of (circle) 2, 3, 4

RANGE OF MOTION PROGRAM

* 3 reps per joint BID to:
Upper Extremity:
☐ R ☐ L ☐ None Indicated
Lower Extremity:
☐ R ☐ L ☐ None Indicated
Contracture:
☐ No ☐ Yes
Location:

SPLINTS-ORTHOTICS & WEARING SCHEDULE

Upper Extremity	Lower Extremity
☐ R ☐ L ☐ None	☐ R ☐ L ☐ None
Type:	Type:
On:	On:
Off:	Off:
Other:	Other:

Precautions / Other:

Signature / Title / Date Updated:_____