Admission Assessment Work Sheet

Name:__________________________

DOB:__________________________

For question 1-3, answer with **Y** (yes), **N** (no), **?** (unknown) or **NA** (not applicable).

1. **Treatment for Diabetes**
   - Diet only _____
   - Pills _____
   - Insulin _____
   - Pills and insulin _____
2. **Blood Sugar Levels**
   - Last A1c value ______ Date: ____________
   - Is resident aware of signs and symptoms of low blood sugar? _____
   - Is resident aware of sign and symptoms of high blood sugar? _____
3. **Diabetes and related conditions**
   - Cardiovascular Disease Diagnosed _____
     - High blood pressure _____
     - High cholesterol _____
     - Previous heart attack _____
     - Previous stroke _____
   - Blood Pressure
     - Lying down ______ Pulse ______ R or L arm (circle one)
     - Standing ______ Pulse ______ R or L arm (circle one)
     - Orthostatic hypotension (low blood pressure) _____
       - do orthostatic vitals on admission
   - Dental Disease
     - Gum disease _____
     - Poor dentition (from missing or crooked teeth) _____
     - Dentures _____
     - Decayed teeth _____
   - Eye Disease
     - Poor vision _____
     - Glasses _____
     - Glaucoma _____
     - Cataracts _____
   - Kidney Disease Diagnosed _____
     - Frequent urine infections _____
     - Urinary incontinence _____
     - Pain or burning on urination _____
     - Incontenance _____
   - Mental Health
     - History or symptoms of anxiety _____
     - History or symptoms of depression _____
   - Nerve Damage
     - Numbness or tingling in hands, feet or legs _____
       - Location ______________________________________
     - Problems with balance or walking _____
   - Gastro-intestinal system
     - Gastric distress, nausea or vomiting _____
     - Loss of bowel control _____
4. **Smoking Status** ☐ Never smoked ☐ Quit (# Years___) ☐ Smokes (Packs/day___)

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5. Blood sugar testing 4 times daily for one week

	Day 1 Values	Day 2 Values	Day 3 Values	Day 4 Values	Day 5 Values	Day 6 Values	Day 7 Values
Before breakfast							
Before lunch							
Before dinner							
Before bedtime							

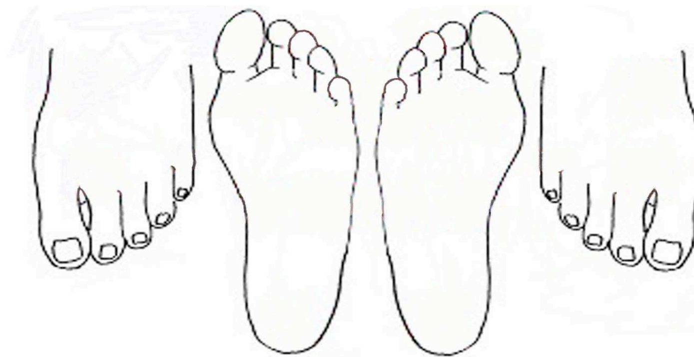
6. Medical nutrition therapy

- Diet orders ______________________________
- Weight ______________________________
- Ability to swallow ______________________________
- Intake ______________________________
- Preferred eating pattern ______________________________

7. Foot examination – Mark as **Y** (yes), **N** (no) or **NA** (not applicable) for each foot

	Right	Left
a. Are their any sores on the foot (ulcers)?		
b. Is the skin on the foot broken?		
c. Does the foot feel warm?		
d. Does the foot feel cold?		
e. Is the skin dry but not cracked or injured?		
f. Is the skin too moist?		
g. Is the skin discolored?		
h. Does the foot have any calluses?		
i. Are the toenails thick?		
j. Do the toenails need to be trimmed?		
k. Are the toenails ingrown?		
l. Is there edema (swelling)?		
m. Is the foot deformed?		
n. Does the resident have numbness, tinkling or burning in the foot?		
o. Is the resident wearing shoes that fit well?		
p. Is there an area where the resident cannot feel a monofilament?		
q. Can you feel a pedal pulse?		

Use this diagram to indicate the location of any problems found.



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