INTRODUCTION

The purpose of the Uniform Assessment Instrument (UAI) is to collect information regarding an assisted living applicant/resident’s physical condition, medical status and psychosocial needs. The information is to be used to: (1) determine if an applicant meets eligibility for entrance or retention in an assisted living facility; (2) if admitted, determine the appropriate level of care for the resident and develop a service agreement; and (3) update service needs and the service agreement.

A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission and no later than day of admission. In all cases the assessment will be completed prior to admission. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident’s condition.

Regulation 5.9 states that the Assisted Living facilities shall not admit, provide services to, or permit the provision of services to any individual with any of the following conditions: Check whether these conditions are present:

- Requires care by a nurse that is more than intermittent or for more than a limited period of time.
- Requires skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or reasonable potential of, an acute episode unless there is a RN to provide appropriate care.
- Requires monitoring of a chronic medical condition that is not essentially stabilized through available medications and treatments.
- Is bedridden for more than 14 days.
- Has developed stage three or four skin ulcers.
- Requires a ventilator.
- Requires treatment for a disease or condition that requires more than contact isolation.
- Has an unstable tracheostomy or has a stable tracheostomy of less than six months’ duration.
- Has an unstable peg tube.
- Requires an IV or central line with an exception for a completely covered subcutaneously implanted venous port, provided the assisted living facility meets the following standards: 1) Facility records shall include the type, purpose and site of the port, the insertion date, and the last date medication was administered or the port flushed; 2) The facility shall document the presence of the port on the Uniform Assessment Instrument, the service plan, interagency referrals and any facility reports; and 3) The facility shall not permit the provision of care to the port or surrounding area, the administration of medication or the flushing of the port or the surgical removal of the port within the facility by facility staff, physicians or third party providers.
- Wanders such that the assisted living facility would be unable to provide adequate supervision and/or security arrangements.
- Exhibits behaviors that present a threat to the health or safety of themselves or others, such that the assisted living facility would be unable to eliminate the threat either through
immediate discharge or use of immediate appropriate treatment modalities with measurable documented progress within 45 days.

☐ Is socially inappropriate as determined by the assisted living facility such that the facility would be unable to manage the behavior after documented, reasonable efforts such as clinical assessments and counseling for a period of no more than 60 days.

If any of these conditions are present and the resident/applicant is not receiving Hospice care, assisted living is not appropriate for the resident/applicant. If the resident is receiving Hospice care, the above restrictions do not apply, provided that the Hospice program: 1) is licensed by the Department of Health and Social Services and 2) provides written assurance that, in conjunction with care provided by the assisted living facility, all of the resident's needs will be met without placing other residents at risk.
SECTION ONE - General Information

Resident Name (Last, First, MI)___________________________________________________________

SS #_____________________  DOB:________________  Sex:  ☐ male  ☐ female

Date of Admission:__________

Assessment (√ one):  Source of Information (√ all that apply)
☐ Initial  date__________  ☐ Self
☐ 30-day  date__________  ☐ Family
☐ Significant Change  date__________  ☐ Healthcare Provider
☐ Annual  date__________  ☐ Other

SECTION TWO - Functional Abilities, Supports, and Related Information

Activities of Daily Living (ADLs)

1. Eating Meals
   A Independent
   B Supervision, set up, cuing, coaching, reminders of meal times
   C Fluid and food intake recorded for each meal/supplements/snacks; and/or observation due to chewing, swallowing, eating difficulties
   D Must be fed; needs tube feeding; 1:1 observation/assistance

2. Toileting
   A Toilets self; completes own hygiene including incontinence care; colostomy/catheter self-care
   B Assist with empty, flush, hygiene after use; toilets self during day; assisted at night
   C Needs observation/standby/transfer assist during toileting; output monitored/recorded by staff
   D Unable to toilet self or self manage incontinence; needs colostomy/catheter assist; requires formal bowel/bladder incontinence program

3. Mobility
   A Independent (or with assistive device)
   B Supervision, cuing and coaching
   C Occasional physical assistance required
   D Walks/wheels only with physical assistance

4. Bed Mobility
   A Independent (or with assistive device)
   B With supervision, cuing and coaching
   C One person physical assistance
   D Two person physical assistance, needs complete assistance

5. Use of Stairs
   A Independent (or with assistive device)
   B With supervision, or standby, or cuing and coaching
   C One person physical assistance
   D Two person physical assistance, or unable to use stairs

6. Transferring
   A Transfers self
   B Needs standby assistance during transfers
   C One person physical assistance
   D Two person physical assistance; needs complete assistance or mechanical assistance (e.g. Hoyer lift)
7. **Grooming:** oral hygiene, make-up, shaving, hair, nail care  
   A Independent  
   B Needs set up  
   C With supervision, cuing and coaching  
   D Needs complete assistance

8. **Dressing**  
   A Independent  
   B With supervision, or set-up, or cuing and coaching.  
   C With physical assistance  
   D Needs complete assistance

9. **Bathing**  
   A Bathes self  
   B Bathes with reminders/prompts  
   C Needs to be set up with water and supplies; needs occasional assistance with back, feet, peri-care  
   D Needs complete assistance or constant supervision

10. **Medication Management**  
    A Independent  
    B Reminders  
    C Set-up or assistance  
    D Administration of medication

11. **Emergency Response**  
    A Independent (or with assistive device)  
    B With supervision, cuing and coaching  
    C One person physical assistance  
    D Two person physical assistance, needs complete assistance

### Assistive Devices and Medical Equipment (Please check all that apply)

<table>
<thead>
<tr>
<th>MOBILITY</th>
<th>Currently Uses</th>
<th>Requires Assessment to Determine Need</th>
<th>Requires Assessment to Determine Need</th>
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<tbody>
<tr>
<td>Cane</td>
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<tr>
<td>Walker</td>
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<tr>
<td>Wheelchair (electric)</td>
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<tr>
<td>Wheelchair (manual)</td>
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<td>Oxygen</td>
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<td>Positioning Device</td>
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<td>Grab Bars</td>
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<tr>
<td>Raised Toilet Seat</td>
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<td>Interpreter (Language)</td>
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<td>Interpreter (Sign)</td>
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<tr>
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<tr>
<td>Grab Bar/Tub Rail</td>
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<td>Other</td>
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</tbody>
</table>
SECTION THREE - Health Information

Primary Physician’s Name: ______________________________________
Telephone:_______________  Fax:_______________________

Most Recent Hospitalization - date and reason: ___________________________________________________________

Vital Signs:   BP___________   T_____________  P____________  R________________

Physical and Mental Health (check all that apply)
Onset (if known)

Neurological Disorders/Developmental Disabilities
☐ Brain Injury
☐ Seizure disorder/Epilepsy
☐ Spinal Cord Injury, _____Level
☐ Stroke
☐ Paralysis
☐ Dementia/Alzheimer’s
☐ ALS
☐ Multiple Sclerosis
☐ Mental Retardation
☐ Autism
☐ Cerebral Palsy
☐ Parkinson’s
☐ Other________________________

ALLERGIES
☐ Food:

☐ Latex

☐ IV Contrast

☐ Other

Eye Disorders
☐ Cataracts
☐ Glaucoma
☐ Macular Degeneration
☐ Blindness
☐ Other________________________

Metabolic Disorders
☐ Diabetes: _____Type I   _____Type II
☐ Renal: _____Dialysis   _____Chronic Renal Failure
☐ Thyroid: _____Hyper   _____Hypo
☐ Other________________________

Musculoskeletal
☐ Amputation
☐ Arthritis: _____Osteo   _____Rheumatoid
☐ Osteoporosis
☐ Fractures
☐ Weakness
☐ Other________________________

Cardio/Vascular/Pulmonary Disorders
☐ Congestive Heart Failure
☐ Hypertension
☐ Myocardial Infarct
☐ ______CABG   ______Valve Surgery
☐ ______Afib   ______V-tach   ______AICD   ______PACER   ______Angina
☐ Peripheral Vascular Disease
☐ COPD: _____Asthma   _____Asbestosis   _____Emphysema
☐ _____Chronic Bronchitis
☐ Pneumonia
Sleep Apnea
Shortness of Breath
Other

Gastrointestinal Disorders
Stomach: _____GERD _____Ulcers
Liver: _____Hepatitis _____Cirrhosis
Intestinal: _____Colitis _____Diverticulosis _____Hemorrhoids _____Constipation _____Loose Stools
Bowel Incontinence
Other

Hematologic/Oncological Disorders
Anemia
Cancer
Immune System Disorder
Other

Psychiatric
Anxiety Disorders
Bipolar
Major Depression
Schizophrenia
Other

Infectious Disease Disorders
Hepatitis _____A _____B _____C
HIV/AIDS
TB
MRSA
VRE
Other

GenitoUrinary Disorders
Incontinence
Urinary Tract Infection
Nocturia

Past Surgeries (date, if known)
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

All Other Problems
_________________________________________________________________________________________
_________________________________________________________________________________________

HOSPICE
Is the resident currently receiving or arranging for hospice care?
□ Yes            □ No
If Yes, name of provider
_________________________________________________________________________________________
VISION (☐ - check one)
☐ Sees adequately with or without corrective lenses
☐ Impaired vision, describe________________________________________________________
☐ Blind in _____left, ____right, _____both

HEARING (☐ - check one)
☐ No impairment
☐ Hard of Hearing
☐ Requires hearing aids
☐ Deaf - Means of Communication________________________________________

TEMPORARY SENSORY IMPAIRMENT
Taste_____ Touch/Pain_____ Smell_____ Hearing_____ Sight_____  

NUTRITION/HYDRATION
Height________________________ Weight________________________

Nutritional Risk Information
Yes ☐ No ☐
☐ ☐ Does resident have dental or mouth problems that make it hard to chew or swallow?
☐ ☐ Does resident have dentures (☐ top ☐ bottom)?
☐ ☐ Does resident have an illness or condition that changes the kind of food and/or amount of food eaten?
☐ ☐ Has resident had a 10% or more unplanned weight change in the last month?
_____________gain _______________loss

Hydration Risk Information
Yes ☐ No ☐
☐ ☐ Does resident require monitoring for hydration?

Diet Information
Please specify any special diet(s) from the choices below:
☐ ADA calorie-calculated ☐ Low cholesterol
☐ Regular diet with added supplements ☐ Liquid
☐ Mechanically altered ☐ Low fat
☐ Restricted sodium ☐ Other________________________
☐ Consistent Carbohydrate

Is resident following the diet? _____yes _____no

SLEEP PATTERNS:
The resident usually goes to bed at __________________________
The resident usually wakes up at________________________
Does the resident take frequent naps? ☐ Yes ☐ No
Does the resident have difficulty sleeping at night? ☐ Yes ☐ No
Is the resident agitated at night? ☐ Yes ☐ No

If yes, please elaborate as to the frequency and type of disturbance:
________________________________________________________________________
________________________________________________________________________
FALL RISK ASSESSMENT

Identify any conditions and/or factors currently present that may increase the resident’s risk of falling and/or suffering injury from a fall (check all that apply):

- Paralysis
- Orthostatic Hypotension
- Osteoporosis
- Gait Problem
- Impaired balance
- Confusion
- Parkinsonism
- Amputation
- Pain
- TIA
- Dizziness/Vertigo
- Unstable transition from seated to standing position
- Balance problems when standing
- Limits activities due to fear of falling
- Fell in last 30 days
- Fell in last 31-180 days
- Other (describe)_________________________________

SMOKING HABITS

Does resident smoke?  □ yes  □ no
If yes, does resident smoke -  □ indoors  □ outdoors
Is resident receiving oxygen therapy?  □ yes  □ no
Describe any safety concerns pertaining to the resident’s smoking habits:

ALCOHOL HABITS

Does resident drink alcoholic beverages?  □ yes  □ no
How many drinks per week?  ___________________
Has the resident ever had any health and/or personal problems due to his/her intake of alcohol?  □ yes  □ no

SKIN CARE/TREATMENTS

Skin ulcers  □ yes  □ no
Type  □ pressure  □ Stasis
Stage (1,2)  ____________
- Reddened areas/frequent assessments
- Decubitus care required (stages 1, 2)

Current Skin Condition: (check all that apply)
- Normal skin care required, including diabetic skin assessment
- Dry skin requires frequent lotioning
- Wound care required for Stage 3, 4 (Hospice only)
- Bruises, abrasions
- Cancerous lesions
- Rash (eczema, herpes zoster, etc.)
- Skin tears
- Other (describe)_________________________________

Skin Treatment: (describe)  __________________________________________  __________________________________________
**PAIN MANAGEMENT**

Does resident have pain?  
- □ Intermittent  
- □ Constant  
- □ Not Applicable

Location of Pain: ___________________  
Pain Intensity on a scale of 0 to 5:  
- Now:___  
- On Average (usual):___

What, if any, medications are taken for pain relief?  
___________________________________________________________________

What, if any, other treatment is resident receiving for pain?  
___________________________________________________________________

Is pain satisfactorily controlled with treatment?  
___________________________________________________________________

---

**PAIN INTENSITY SCALE**

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<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tr>
<td>No pain</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Very Severe</td>
<td>Worst Possible</td>
<td></td>
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Which word(s) describe your pain?  
- ☐ Sore  
- ☐ Heavy  
- ☐ Sharp  
- ☐ Dull  
- ☐ Shooting  
- ☐ Pressing  
- ☐ Burning  
- ☐ Cramping  
- ☐ Aching  
- ☐ Stinging  
- ☐ Tingling  
- ☐ Another word_____________________

---

**MEDICATIONS**

☐ CHECK HERE IF NO PRESCRIBED MEDICATIONS

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<tr>
<th>Prescribed Name/Dosage</th>
<th>Frequency</th>
<th>Route</th>
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<th>Non-Prescription/Herbal Name/Dosage</th>
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<th>Route</th>
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<th>Medication Allergies /Adverse Reactions</th>
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<td>PPD</td>
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<td>Influenza</td>
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**Route Codes**

- Oral
- NG/Gastric Tube
- Rectal
- Topical (site)
- Inhaled: Metered Disc inhaler/Aerosol (MDI)
- IM (site)
- Subcutaneous (sc)(site)
- Vaginal

---

**Frequency Codes**

- Once a day
- BID (2 x a day)
- TID (3 x a day)
- QID (4 x a day)
- HS (at bedtime)
- 5 or more/24 hours
- PRN (as needed)
- 2-3 x a week
- 4-5 x a week
TREATMENTS/ THERAPIES: Identify physician ordered/referred, or authorized services resident currently receives

<table>
<thead>
<tr>
<th>Service</th>
<th>Self-Arranged or Self-Administered</th>
<th>Arranged by Facility</th>
<th>Administered by Facility</th>
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<tr>
<td>Behavior Management Program</td>
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TESTING/MONITORING: Describe any assistance required to facilitate treatments/therapies, including specifying any assistance provided by family member/support person:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Does a recommendation need to be made that the resident see a physician for a medical problem not being addressed?

☐ Yes  ☐ No

If Yes, describe medical problem:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

SECTION FOUR - Psychological/Social/Cognitive Information

**Background Information**

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<tr>
<th>Orientation: Indicate Yes or No</th>
<th>Person</th>
<th>Place</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>短期记忆力正常，似乎在五（5）分钟后可以回忆：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>长期记忆力正常，似乎/似乎可以记起长期过去：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>感到焦虑：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>表达悲伤、愤怒、空虚感对失去角色或地位：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>缺乏与家庭成员/朋友的个人接触：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>比其他人居民更容易情绪低落：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>问题理解自我的：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>问题理解他人：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>历史对自我和/或其他的危险：</td>
<td>✔️ Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>历史的徘徊：</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td></td>
</tr>
</tbody>
</table>
|历史的： | ☐ Disruptive  ☐ Socially inappropriate  ☐ Assaulative  ☐ Destructive  ☐ Demanding behaviors.  Please describe:

________________________________________________________________________________

Resists care: Refuses to bathe, eat, medicate, care for self, allow others to assist, etc.

☐ Yes  ☐ No

If yes, please describe:

________________________________________________________________________________

10
THIS INSTRUMENT IS A BASELINE DETERMINATION. IT IS THE RESPONSIBILITY OF THE FACILITY TO ANALYZE THE DATA COLLECTED HEREIN AND REFER FOR, AND/OR CONDUCT, FURTHER EVALUATION AS NEEDED.

The applicant/resident represents that all oral and/or written information made or furnished by, or on behalf of, the applicant for completion of the Uniform Assessment Instrument are true and accurate to the best of his/her knowledge and belief. The applicant understands and acknowledges that providing this information does not represent a commitment for, or guarantee of, service or admission to an Assisted Living Facility and is provided solely for the purpose of evaluation.

Signature
Print Name
Date

Applicant/Resident

Legal Representative, if applicable

UAI completed by:

Registered Nurse
License #: _________________________
State of Licensure: _________________________

☐ 30 Day Assessment (date) _______________ ☐ No Change ☐ Change

Signature (RN) Date