Patient Identification Label

RAI Screening Assessment

PRINT NAME	**FORM COMPLETED BY:**
LAST _____ FIRST_____ M _____	PATIENT ☐ OTHER _____
AGE _____	
GENDER ☐ MALE ☐ FEMALE	

Instructions: Please answer the following questions to the best of your ability. Your advocate or companion can help you complete this survey.

Where You Live

1. Do you live in place other than your own home? ☐ No ☐Yes

If Yes, circle where: Nursing Home Skilled Nursing Facility Assisted Living Other_____

When did you begin living in the place you are currently residing? ☐Less than 3 months ☐3 months to 1 year ☐Greater than one year ago

Medical Conditions

2. Any kidney failure, kidney not working well, or seeing a kidney doctor (nephrologist)? ☐ No ☐Yes

If Yes, circle one: was your nephrologist visit for ☐Kidney stones ☐Other ☐Both Kidney Stones and Other problems

3. Any history of chronic (long-term) congestive heart failure (CHF)? ☐ No ☐Yes

4. Any shortness of breath when resting? ☐ No ☐Yes

Prompt: Do you have trouble catching your breath when resting or doing minimal activities, like walking to the bathroom?

5. In the past five years, have you been diagnosed with or treated for cancer? ☐ No ☐Yes

Prompt: Please answer "Yes" if the clinic visit today is to discuss the possibility of cancer surgery.

Nutrition

6. Have you lost weight of 10 pounds or more in the past 3 months without trying? ☐ No ☐Yes

Prompt: Are your clothes feeling looser than in the past?

7. Do you have any loss of appetite?

Prompt: Do you or your family notice that you are not eating as much? ☐ No ☐Yes

Cognitive

8. During the last 3 months has it become difficult for you to remember things or organize your thoughts? ☐ No ☐Yes

Activities of Daily Living

9. Getting around (mobility)	☐ Can get around without any help	☐ Needs help from a cane, walker or scooter	☐ Needs help from others to get around the home or neighborhood	☐ Needs help getting in or out of a chair	☐ Totally dependent on others to get around
10. Eating	☐ Can plan and prepare own meals	☐ Needs help planning meals	☐ Needs help preparing meals	☐ Needs help eating meals	☐ Totally dependent on others to eat meals
11. Toileting	☐ Can use toilet without help	☐ Needs help getting to or from toilet	☐ Needs help to use toilet paper	☐ Cannot use a standard toilet, with help can use bedpan/urinal	☐ Totally dependent on others for toileting
12. Personal hygiene (bathing, hand washing, changing clothes	☐ Can shower or bathe without prompt or help	☐ Can shower or bathe without help when prompted	☐ Needs help preparing the tub or shower	☐ Needs some help with some elements of washing	☐ Totally dependent on others to shower or bathe