# ARMED FORCES RETIREMENT HOME
## Functional Assessment

**March 2018**

This assessment is required for all applicants seeking admission to the Armed Forces Retirement Home and must be completed and signed **ONLY by a licensed occupational or physical therapist; NOT by a doctor, nurse or other healthcare practitioner, or the resident candidate.** Please answer the following questions based on your professional judgment, observation and functional tests administered during the applicant's visit. Answers are subject to verification for accuracy purposes **and all "Yes" answers need to be explained**. "Yes" answers may or may not affect your application approval.

## Activities of Daily Living (ADL)

**1. Requires and/or receives assistance using the phone?** (such as: dialing, receiving, calling 911)

Yes ☐ No ☐

If yes, explain: _____

_____

**2. Requires and/or receives assistance traveling?** (such as: planning, driving, bus, plane, taxi usage)

Yes ☐ No ☐

If yes, explain: _____

_____

**3. Requires and/or receives assistance on incline, decline or curbs?**

Yes ☐ No ☐

If yes, explain: _____

_____

**4. Requires and/or receives assistance shopping?** (such as: clothes, hygiene, grooming products)

Yes ☐ No ☐

If yes, explain: _____

_____

**5. Requires and/or receives assistance to recall current events, locations, dates, names**

Yes ☐ No ☐

If yes, explain: _____

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Address

6. **Requires and/or receives assistance with the preparation and intake of medications?**

Yes ☐ No ☐

If yes, explain: _____

_____

**7. Requires and/or receive assistance with meals** (ie. Feeding, carrying tray, diet

Yes ☐ No ☐

If yes, explain: _____

_____

Specific needs(adaptive equipment): _____

**8. Requires and/or receives assistance with maintaining/cleaning living quarters and personal laundry?** (such as: sweeping/vacuuming, making bed, cleaning bathroom, washing garments)

Yes ☐ No ☐

If yes, explain: _____

_____

**9. Requires and/or receives assistance with personal hygiene?** (such as: bathing, grooming, dressing)

Yes ☐ No ☐

If yes, explain: _____

_____

Specific needs (grab bar, bath stool, supervision, etc): _____

_____

**10. Requires and/or receives therapy services**? (to address weight, pain, cognition, ADL, wound care)

Yes ☐ No ☐

If yes, explain: _____

_____

**11. Requires and/or receives assistance of a mobility device?** (such as: Wheelchair, person, cane, walker, etc)

Yes ☐ No ☐

If yes, specify type: _____

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**12. Requires and/or receives assistance with toileting?** (i.e. transfer, removing/reapplying clothes)

Yes ☐ No ☐

If yes, explain: _____

_____

Specific needs (colostomy, ileostomy, catheter, raised seat, grab bar, bed pan, incontinent supplies, etc.)

_____

**13. Requires and/or receives assistance with transfers?** (from chair, bed, bath, vehicle, etc.)

Yes ☐ No ☐

If yes, explain: _____

_____

Specific needs (mechanical device, grab bars, lift system, etc.) _____

_____

**14. Requires and/or receives assistance for daily decision making?** (such as: Cues, supervision)

Yes ☐ No ☐

If yes, explain: _____

_____

**15. The individual currently lives or has lived in the past 6 months?** (Circle all that apply)

| | | |
|---|---|---|
| Alone | Assisted Living Facility | Apartment |
| With Family Member | Nursing Home | House |
| With Caretaker | Senior Housing | Other |

**16. The individual uses the following mobility devices on a daily basis?**(Circle all that apply

| | | |
|---|---|---|
| Wheelchair (manual) | Raised Toilet Seat | Escort |
| Wheelchair/Scooter/ Battery Powered Vehicle (electric) | Grab Bars | Recliner Chair that lifts one to their feet |
| Cane/ Walker/Crutch | Shower Chair / Bathing Stool | Other: _____ |

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**17. Furthest distance walked during this session?**(Circle one; can include resting periods)

| | | |
|---|---|---|
| 150+ feet | 51-149 feet | 26-50 feet |
| 10-25 feet | less than 10 feet | Unable to walk |

**Explain, if needed:** _____

**18. Walking support used during this demonstration?** (Circle all that apply)

| | | |
|---|---|---|
| None | Cane/Walker/Crutch | Oxygen/ breathing equipment |
| Parallel Bars | Prosthesis | 1-2 persons assisting |
| | Seeing -Eye Dog | Other:_____ |

**19. Able to transfer from mobility device to toilet, bed, etc. without assistance/falling?**

**_____ Yes** **_____ No** **_____ N/A**

## Assessment Information

**20. Who participated in this assessment?** (Circle all that apply)

| | | |
|---|---|---|
| Individual | Family Member | Significant Other |
| Caretaker | Friend | Other: |

**This form must be completed and signed ONLY by a licensed occupational or physical therapist; not by a doctor, nurse or other healthcare professional, or the potential resident.** Your signature indicates that you have assessed this individual and the answers to the questions are accurate based on your professional judgment **as a licensed occupational or physical therapist.**

_____ _____

Signature and Title (sign on above line) Print Name

License Number/State _____ Telephone Number _____

Date Assessment Completed _____Email Address:_____

## Return to:

Armed Forces Retirement Home
Public Affairs Office #584

Last Name First Name Middle Initial

Address

3700 North Capitol Street, NW Washington, DC 20011-8400
Fax Number: (202) 541-7519

Last Name First Name Middle Initial

Address