NURSING ORDER/REQUEST FOR CUSTOMER REHABILITATION SCREEN

Before request is made, documentation of change in condition must be noted in Nurses Note section of Resident's chart.

Resident's Name: _____ Date: _____

Room #: _____

Screen requested by Nursing /Caregivers: Customer Problems Noted **(check changes in condition).**

- ☐ Difficulty feeding self
- ☐ Difficulty w/ grooming/hygiene
- ☐ Difficulty dressing
- ☐ Unable to get on/off toilet
- ☐ Weakness
- ☐ Contractures
- ☐ Limited range of motion
- ☐ Joint pain/swelling
- ☐ Unable to follow directions
- ☐ Vision problems
- ☐ Does not look left/right
- ☐ Unable to use hands in task
- ☐ Hand/wrist splint causing redness or other problems
- ☐ Poor position in w/c
- ☐ Restraint
- ☐ Poor problem solving skills
- ☐ Open area due to positioning
- ☐ Unable to maneuver w/c
- ☐ Pressure relief w/ cushion
- ☐ Other _____

- ☐ Slurred speech
- ☐ Drooling
- ☐ Choking
- ☐ Coughing
- ☐ Pocketing food
- ☐ Weight loss
- ☐ Jargon
- ☐ Unable to follow directions
- ☐ Orientation deficits
- ☐ Nonverbal
- ☐ Incorrectly names objects
- ☐ Unable to maintain topic
- ☐ Poor judgement
- ☐ Poor problem solving
- ☐ Memory problems
- ☐ Easily distracted
- ☐ Hearing problems
- ☐ Other _____

- ☐ Shuffle gait
- ☐ Unsteady gait
- ☐ Frequent falls
- ☐ Weakness
- ☐ Pain
- ☐ Unable to get in/out of chair
- ☐ Unable to get in/out of bed
- ☐ Splint/AFO causing redness or other problems
- ☐ Contractures
- ☐ Limited range of motion
- ☐ Needs assist w/ walking or transferring
- ☐ Restraints
- ☐ Other _____

Patient's prior level of function:_____

_____

_____

Comments: _____

_____

_____

Nursing Signature: _____ **Date:** _____

Therapist Follow Up:

_____

_____

_____

Discipline (circle one): PT OT ST

Therapist Signature: _____ **Date:** _____