

# 45-DAY NURSING ASSESSMENT

To be completed at least every 45 days or sooner if needed.

Resident Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Next 45-day Nursing Assessment Due: \_\_\_\_\_

Date of Admission: \_\_\_\_\_

**ALLERGIES** – Indicate any changes.

**DIAGNOSES** – Indicate any changes.

| VITAL SIGNS | P | R | T | °F | WT | ft | in | WT CHANGE: <input type="checkbox"/> NO <input type="checkbox"/> YES |
|-------------|---|---|---|----|----|----|----|---|
| BP          | P | R | T |    |    |    |    |   |

**RESIDENT** (If the resident has any wounds, a separate wound assessment form must be attached.)

**GENERAL PHYSICAL FINDINGS:**

**HOSPITALIZATIONS/PHYSICIAN VISITS SINCE LAST REVIEW:**

**VITAL SIGNS OR LAB MONITORING COMPLETED AS REQUIRED:**  YES  N/A  NO (SPECIFY)  
**RESULTS WITHIN NORMAL LIMITS:**  YES  N/A  NO (SPECIFY)

**MEDICATION/TREATMENTS**

**CHANGES SINCE LAST REVIEW:**

**RESULTS OF REVIEW OF MAR, MEDICATIONS, AND ORDERS:**

**EFFECTIVENESS OF MEDICATIONS/TREATMENTS:**

Resident: \_\_\_\_\_

Date Completed: \_\_\_\_\_

MEDICATION/TREATMENTS (continued)

SYMPTOMS, SIDE EFFECTS, ADVERSE REACTIONS:

APPROPRIATE STORAGE:  YES  NO (IF NO, EXPLAIN ISSUE IN FOLLOWING SECTION)

MEDICATION TECHNICIAN

PROBLEMS ENCOUNTERED REGARDING DOCUMENTATION, ADMINISTRATION, COMPETENCY, STORAGE, ETC.:

ACTIONS TAKEN, IF PROBLEMS ENCOUNTERED: (INDICATE THE PROBLEM, DATE OF PROBLEM, MED TECH'S NAME, INTERVENTION (REMEDIATION, VERBAL WARNING, ETC), AND FOLLOW-UP PLAN)

ENVIRONMENT

IS THE ENVIRONMENT SAFE FOR THE RESIDENT?  YES  NO (SPECIFY)

OVERALL

RECOMMENDATIONS AND FOLLOW-UP ACTIONS:

RN's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_