COGNITIVE/PHYSICAL DATA FORM

SAN DIEGO DEMENTIA CONSORTIUM

SENT TO: (Name of Hospital) _____ SENT FROM: ☐Home ☐Doctor ☐ Facility Date ____/_____/_____

Resident: Last Name: _____ First Name _____ MI_____
DOB:____/____/_____ SSN:_____ Language: ☐English ☐Other _____
REASON FOR TRANSFER (i.e., What Happened?):_____
_____

Primary Physician: _____ Phone (_____) _____-_____
Contact: Relationship: Check one
Relative ☐ DPOA ☐ Other ☐ _____ Called contact ☐ Contact Coming to ER ☐
Contact Name_____Telephone: (_____)_____-_____

FACILITY CONTACT: NAME: _____ TITLE_____
TELEPHONE (_____)_____ - _____

CODE STATUS: ☐ FULL CODE ☐ DNR ☐ POLST

PATIENT BASELINE DATA

Allergies_____
Usual Mental Status:
☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, but cannot follow simple instructions
☐ Not Alert
☐ Dementia
☐ MCI (Mild Cognitive Impairment)

AT RISK ALERTS
☐ None
☐ Falls/Last_____
☐ Pressure ulcer
☐ Wanderer
☐ Other_____
☐ Seizures
☐ Harm to:
☐Self ☐ Others
☐ Limited/non-weight bearing:
☐ Left ☐ Right

Disabilities:
(Amputation, paralysis, contractures)

Impairments:
☐ Wears Glasses
☐ Wears Hearing Aid
☐ Communication Problems
☐ Dentures

Incontinence: ☐ Yes ☐ No Bladder ☐ Yes ☐ No Bowel

Diet: Appetite: ☐ Good ☐ Fair ☐ Poor
Assistance with Feeding ☐ Yes ☐ No
Trouble Swallowing ☐ Yes ☐ No
Special Consistency: regular ☐, chopped ☐, pureed ☐, thickened liquids ☐, crush meds ☐

Mark one I= independent, D=Dependent, A= needs assistance, U= unknown
____ Bathing _____Dressing
____ Toileting/Transfer _____ Can Ambulate ____ft.
____Eating
____Needs: wheelchair ☐ Walker ☐ Cane ☐
Sleeps: Well ☐ Needs Assistance ☐

Medications:_____
_____
Med list enclosed with paperwork

Mental Test Score:
_____ MMSE _____ Other

Form Completed By:

Name	Phone	Signature	Date
_____	_____	_____	_____