RAI Screening Assessment

**PRINT NAME**
LAST ___________________________ FIRST ___________________________ M ______

**AGE ___________________________**
**GENDER** □ MALE □ FEMALE

**FORM COMPLETED BY:**
PATIENT □ OTHER _________

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?
   - Prompt: Do you have trouble catching your breath when resting or doing minimal activities, like walking to the bathroom?
   □ No □ Yes

5. In the past five years, have you been diagnosed with or treated for cancer?
   - Prompt: Please answer “Yes” if the clinic visit today is to discuss the possibility of cancer surgery.
   □ No □ Yes

### Nutrition
6. Have you lost weight of 10 pounds or more in the past 3 months without trying?
   - Prompt: Are your clothes feeling looser than in the past?
   □ No □ Yes

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