

Carelink Health Care Services, LLC

Comprehensive Assessment

Patient Name: Pamela Justiniano MR#: 6094077695
Date: 5-30-15 Time In: 10am Time Out: 11:54 AM

ADVANCED DIRECTIVES

1. Patient has no Advance Directives-Patient/Caregiver provided written information and education regarding right to implement

Living Will

☒ Patient has no living will.

☐ Patient has a Living Will and a copy is available in the chart.

☐ Patient has a Living Will, but is unable to provide a copy. Patient caregiver-name _____
_____ is able to verbalize content as documented: Contents of Living Will: _____

☐ Patient has a Living Will, but is unable to provide a copy or verbalize content, therefore patient/caregiver informed of agency's inability to honor Living Will.

Power of Attorney: ☒ NA-none ☐ Medical ☐ Financial

Name: _____

Phone: _____ Address: _____

City/State/Zip: _____

Do Not Resuscitate (DNR) Orders (OOHDNR)

☐ Patient does not have DNR orders ☒ Patient has DNR orders ☐ Patient's DNR status is unknown

2. Race/Ethnicity (as identified by patient): (Mark all that apply)

☐ American Indian or Alaska Native ☐ Asia ☐ Black or African-American ☐ Hispanic or Latino

☐ Native Hawaiian or Pacific Islander ☐ White ☐ UK-Unknown ☐ Other: _____

3. Current Payment Sources for Home Care: (Mark all that apply)

☐ None/no charge for current services ☐ Private Pay ☒ Worker's compensation ☐ Insurance

Clinical Record Items

4. Language/Literacy:

Patient Caregiver (If one/both are illiterate, consider alternative methods) ☒ Read ☒ Write ☐ Neither

Highest level of education for:

Patient: _____ Caregiver: _____

Primary language spoken by pt/cg: English Primary language read by pt/cg: _____

Preferred language for education resources: _____

Interpreter: ☐ offered ☐ required

Interpreter's Name: _____ Phone: _____

Comments: _____

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5. Spiritual/Cultural Assessment:

Spiritual/Religious Affiliation: Methodist Spiritual/Religious Contact Name and Phone: _____

Religious/Cultural Practices that may affect health and care:

a. Patient's major support person: _____

b. Patient's food preferences and/or prohibitions: _____

c. Patient's health and illness beliefs and practices: _____

d. Patient's customs/beliefs regarding pain control: _____

e. Patient's customs/beliefs regarding death: _____

Comments: _____

6. Has the patient been in any of the following Inpatient Facilities during the last 30 days? (Mark all that apply)

☐ NA-Patient was not discharged from an inpatient facility ☐ Skilled nursing facility ☒ Hospital

☐ Other nursing home ☐ Rehabilitation facility ☐ Other (specify) Mainland

Most Recent Facility Name: _____ Dates of stay: _____ to 5/24/15

Medical History/Immunizations/Screening

7. Medical History: (Mark all that apply) None

- | | | |
|---|---|--|
| ☐ Asthma | ☐ Diabetes | ☐ Lung Dis./TB |
| ☐ Arthritis/Gout | ☐ Endocrine Disorders | ☐ Mental/Psych Disorders |
| ☐ Blood Disease / Transfusions | ☐ Epilepsy/Seizures | ☐ Neurological Disease |
| ☐ Bone Disease/Fx | ☐ Falls | ☐ Phlebitis/Vascular Disease |
| ☐ Breast Disease | ☐ GI/Gallbladder Disease | ☐ Prostate Disease |
| ☐ Cancer | ☐ Headaches/Migraines | ☐ Reproductive Disease |
| ☐ Cardiac Disease/MI | ☐ Hypertension | ☐ Sexually Transmitted Diseases |
| ☐ Chest Pain/Angina | ☐ Infectious Diseases | ☐ Substance Abuse |
| ☐ Chemical Abuse | ☐ Kidney/Bladder Disease | ☐ TIA/CVA |
| ☐ Dementia | ☐ Liver Disease | ☐ Tobacco Use |

Other: Acid Reflux, Hypercholesterolemia, Anxiety

Explain any checked items. Include treatments or non-surgical procedures used for treatments of DX.

(Environmental, Drugs, Food, etc.)

Allergies: _____

8. Immunizations: (Mark all that apply) ☐ NA-no immunizations

☐ Hepatitis: Type _____ (A/B/C) _____ / _____ (Mo/Yr) ☐ Flu _____ / 2014 (Mo/Yr)

☐ Tetanus/Diphtheria _____ / _____ (Mo/Yr) ☐ Pneumonia _____ / 2015 (Mo/Yr)

☐ Other: _____ / _____ (Mo/Yr)

Comments: _____

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9. Screening: (Mark all that apply) ☒ Female ☐ Male ☐ NA-no screening tests
- ☐ Mammogram / 2014 (Mo/Yr) ☐ Pap Smear / (Mo/Yr) ☐ PSA / (Mo/Yr)
- ☐ Prostate exam / (Mo/Yr) ☐ Other: / (Mo/Yr)
- ☐ Other: / (Mo/Yr)
- ☐ Self Breast Exams: Frequency Last performed / (Mo/Yr)
- ☐ Self Testicular Exams: Frequency last performed / (Mo/Yr)
- Comments: _____

Diagnoses/Procedure/Prognosis

Diagnosis: List each medical diagnosis/condition for which the patient is receiving home care and five digit ICD-9 code.

Primary Diagnosis ICD-9-CM Onset/Exacerbation Date

a. Knee joint replacement (V43.65) O E _____

Other Diagnosis

b. Hypercholesterolemia (272.0) O E _____

c. Acid Reflux (530.81) O E _____

d. Anxiety (300.00) O E _____

e. _____ (_____) O E _____

f. _____ (_____) O E _____

Additional Diagnoses ICD-9-CM Onset/Exacerbation Date

_____ (_____) O E _____

_____ (_____) O E _____

_____ (_____) O E _____

_____ (_____) O E _____

Surgical Procedures (relevant to this plan of care): ☐ A

Procedure ICD-9-CM Date Performed

1. Revision (R) Knee replacement (_____) 4/2015

2. _____ (_____) _____

Surgical History: _____

10. Therapies the patient receives at home: (Mark all that apply) N/A

☐ Intravenous or infusion therapy (excludes TPN) (check this if maintenance flushing of device) See below.

☐ Parenteral nutrition (TPN or lipids)

☐ Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)

☐ None of the above

11. Vascular Access Device(s) (VAD): (Mark all that apply) (Indicate date of insertion, size & location) N/A

☐ Peripheral line _____

☐ Epidural _____

☐ PICC/Passport _____

☐ Intrathecal _____

☐ Midline _____

☐ Subcutaneous _____

☐ Tunneled Central Venous _____

☐ Implanted Port _____

Other _____

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*Assessment of VAD/site? ☐ Yes ☒ No
*Vascular Access Device Flush? ☐ Yes ☐ No Date of last VAD flush ___/___/___
*VAD Dressing/Injection cap change? ☐ Yes ☐ No Date of last dressing/ cap change ___/___/___
*Administer IV Fluids/Medications/TPN? ☐ Yes ☐ No Method of delivery: _____
☐ Gravity: Amount/Frequency _____
☐ Pump: Type/Rate _____
Comments: _____

12. Enteral Access Device (EAD): (Select One) (Indicate date of insertion, size & location) *N/A*

☐ Nasogastric tube _____
☐ Low-Profile Gastrostomy Device _____
☐ Gastrostomy tube _____
☐ Jejunostomy _____
*Assessment of EAD/site? ☐ Yes ☐ No *Enteral Access Device Flush? ☐ Yes ☐ No
*Enteral Access Device Dressing Change? ☐ Yes ☐ No Date of Dressing Change ___/___/___
*Enteral Feedings? ☐ Yes ☐ No
Method of delivery:
☐ Bolus/Intermittent Feedings-Amount/Frequency _____
☐ Pump-Type/Rate _____
*Consider Registered Dietician/Nutritionist eval. if pt. is having difficulty meeting nutritional requirements.
Registered Dietician/Nutritionist Evaluation? ☐ Yes ☐ No

13. Overall Prognosis: BEST description of patient's overall prognosis for recovery from this episode of illness.

☐ Poor ☐ Guarded ☐ Fair ☐ Good ☒ Excellent

Living Arrangements

14. Current Residence:

☒ Patient owns residence ☐ rents residence ☐ lives in assisted living facility
☒ lives with family member ☐ Other (specify) _____

15. Patient Lives With: (Mark all that apply)

☐ Lives Alone ☐ other family member ☐ paid help (other than home care agency staff)
☒ With spouse or significant other ☐ a friend ☐ someone other than above

16. Environmental Assessment: (Mark all that apply) ☒ No safety concerns observed

☐ Unsafe electrical wiring/outlets ☐ Unsanitary conditions ☐ Unsafe use/maintenance of DME
☐ No working phone/inability to use phone ☐ Unsafe gas/electrical appliances
☐ Improper storage of medications/hazardous materials ☐ Unsafe/Inadequate bathroom equipment
☐ Structural barriers ☐ Home in unsafe/high crime area ☐ Other: _____

Explain further any findings: _____

Unsafe/unsanitary conditions addressed as follows: _____

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17. Safety Measures: (Mark all that apply)

- | | | |
|--|--|---|
| ☐ O2 Precautions | ☐ Assistive Devices | ☐ Droplet Infection Control Precautions |
| ☐ Safe Disposal of Sharps | ☐ Standard Precautions | ☐ Contact Infection Control Precautions |
| ☐ Aspiration Precautions | ☐ Safety in ADL's | ☐ Airborne Infection Control Precautions |
| ☐ 24 Hr Supervision | ☐ Bleeding Precautions | ☐ Assist during Ambulation/Transfer |
| ☐ Hand Rails | ☒ Fall Precautions | ☐ Infection Control Precautions |
| ☐ Clear Pathways | ☐ Seizure Precautions | ☐ Anticoagulation Precautions |

Other: 2nd surgical wound; pain

Unsafe/unsanitary conditions addressed as follows: _____

18. Emergency Plan Code/Rating: ☐ Class I ☐ Class II ☒ Class III (per agency policy)

Supportive Assistance

19. Assisting Person(s) other than Home Care Agency Staff: (Mark all the apply)

- ☐ relative, friends, or neighbors outside the home ☐ Paid help ☐ UK-Unknown
☒ Person residing in the home (Excluding paid help) ☐ None of the above

20. Primary Caregiver (responsible person for providing/managing the patient's care, providing the most frequent assistance, etc. not home care agency staff): ☐ No one person

- ☐ Friend or neighbor or community or church member ☐ Paid help
☒ Spouse or significant other ☐ Daughter, son, or other family member ☐ UK-Unknown

Caregiver's ability and willingness to care for patient: _____

Does caregiver availability impact care? ☒ Yes ☐ No

Other individuals or organizations involved in patient's care/further comments: _____

Sensory Status

21. ☐ Vision with corrective lenses if the patient usually wears them:

- ☒ Normal vision: sees adequately in most situations; can see medication labels, newsprint
☐ Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
☐ Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive

22. Eyes Assessment: (Mark all that apply)

Right Eye

- ☐ Jaundice
☐ Cataracts
☐ Drainage
☐ Glaucoma
☐ Prosthesis
☐ Blurred Vision
☐ Redness
☐ Contacts

Left Eye

- ☐ Jaundice
☐ Cataracts
☐ Drainage
☐ Glaucoma
☐ Prosthesis
☐ Blurred Vision
☐ Redness
☐ Contacts

☐ No Problems Reported/Observed Corrective Lenses Prescribed: ☐ NA ☒ Glasses

☐ Itching Does patient usually wear corrective lenses as prescribed? ☐ Yes ☐ No

☐ Edema Comments: reading

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23. Ears Assessment: (Mark all that apply) ☒ No Problems Reported or Observed ☐ Deaf: right/ left/ both
☐ Drainage: right/ left/ both ☐ Redness: right/ left/ both ☐ Tinnitus: right/ left/ both
☐ Hard of Hearing: right/ left/ both ☐ Itching: right/ left/ both ☐ Hearing Aid: right/ left/ both

Comments: _____

24. Nose Assessment: (Mark all that apply) ☐ No Problems Reported or Observed

☐ Congestion ☐ Sinus Problems ☐ Drainage/Bleeding

☐ Altered Smell ☐ Other: _____

Comments: Seasonal allergies

25. Speech and Oral (Verbal) Expression of Language (in patient's own language):

- ☒ Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
☐ Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
☐ Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
☐ Has severe difficulty expressing basic ideas or needs.
☐ Speech limited to single words or short phrases.
☐ Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
☐ Patient is nonresponsive or unable to speak.

26. Does patient have Dysphagia (swallowing difficulty)?

☐ Yes* ☒ No *If yes, include in list of diagnoses

27. Mouth Assessment: (Mark all that apply)

Teeth

- ☒ Natural Teeth
☒ Dentures upper
☐ Partial/Bridge
☐ Edentulous
☐ Chewing Problems
☐ Bleeding

Gums/Oral Mucosa

- ☐ Pink
☐ Pale
☐ Moist
☐ Dry
☐ Edema
☐ Bleeding

Lips

- ☐ Pink
☐ Pale
☐ Cyanotic
☐ Moist
☐ Dry
☐ Cracked

Tongue

- ☐ Pink
☐ Pale
☐ Moist
☐ Edema
☐ Protrusion
☐ Altered Taste Sensation

☒ No problems observed/reported ☐ Odor ☐ TMJ

Lesion-site _____

Lesion-site _____

Lesion-site _____

Other _____

Pain Status

28. Frequency of Pain interfering with patient's activity or movement:

- ☐ Patient has no pain or pain doesn't interfere with activity or movement ☐ Daily, but not constantly
☐ Less often than daily ☒ All of the time

29. Non-Verbal Patient Pain Assessment: (Mark all observed or reported behaviors that may be pain related)

- ☐ None Reported/Observed ☐ Restlessness ☐ Rigidity ☐ Crying ☒ Facial Grimaces
☐ Guarding ☐ Moaning ☐ Other _____

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30. Does pain impact patient's daily functioning? ☒ Yes ☐ No

Comments:

Does the patient take any OTC oral or topical meds (such as NSAID's, Ben-Gay etc.) and/or herbal remedies to obtain pain relief? ☐ Yes ☒ No (Add all OTC/Herbal meds to Medication List.)

31. Describe patient's pain:

Intensity
0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Moderate Severe

Characteristics: A=Ache (Dull) B=Burning C=Crushing R=Radiating S=Sharp T=Throbbing
O=Other (describe)

Location of Pain: R knee surgical site

Current Relief Methods Oral meds, ice, elevation, other

Oxycodone-acetaminophen 5/325mg 1-2 po Q 6°

Goal: (0-10) 0

Comments:

Integumentary Status

32. Does this patient have a Skin Lesion or an Open Wound? Including healed pressure ulcers.

☒ Yes ☐ No

Surgical site

Skin Condition (Record code # on body area.
Indicate size to right of numbered category.)

1 Lesions

2 Bruises

3 Masses

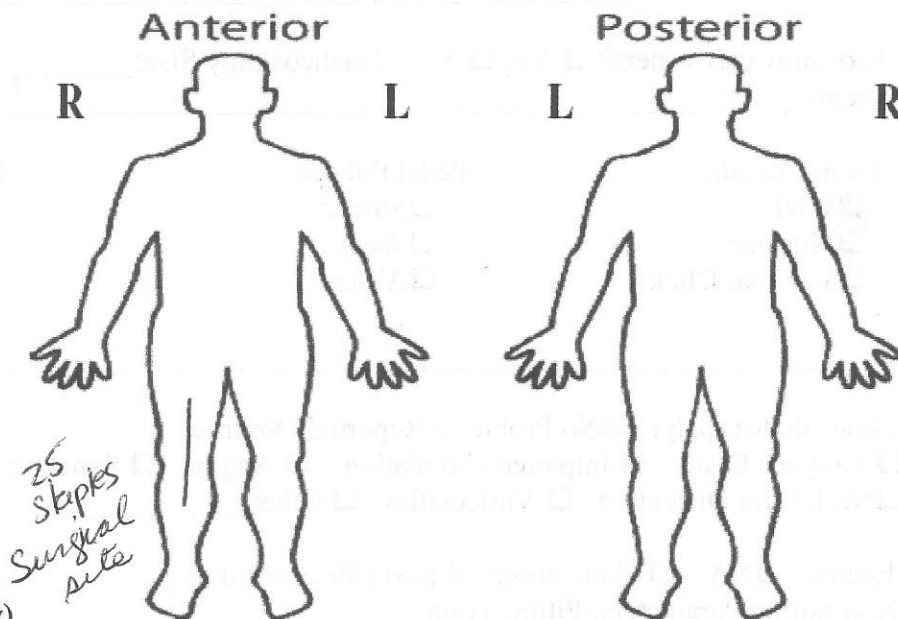
4 Incisions ☒

5 Scars

6 Ulcers

7 Decubiti

8 Pressure areas



33. Skin Assessment: (Mark all that apply)

☐ Good

☐ Jaundiced

☐ Flushed

☐ Moist

☐ Fair

☐ Cool

☐ Pale

☐ Dry

☐ Poor

☐ Warm

☐ Cyanotic

☐ Scaly/Cracked

Turgor

Color

Recent hair loss/growth:

Comments: S/P R Revision knee

34. Document any wounds on the Wound Care Flow Sheet.

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Respiratory Status

35. Is the patient dyspneic or noticeably short of breath?

☒ No ☐ Yes, Explain _____

36. Respiratory Treatments utilized at home: (Mark all that apply) (List settings for each if applicable)

☐ Oxygen (intermittent or continuous) _____ ☐ Continuous positive airway pressure _____
☐ Ventilator (continually or at night) _____ ☐ None of the above

37. Respiratory Assessment ☒ No problems reported or observed

☐ Use of accessory muscles noted ☐ Orthopnea ☐ Apnea
☐ *O2 orders? ☐ Yes ☐ No

Cough:

☒ None reported/heard via _____ ☐ Non-productive Cont. / Intermittent / PRN / HS
Amount _____

Productive: ☐ Clear ☐ Blood-tinged ☐ Brown ☐ Yellow ☐ Green
☐ Other _____

Tracheostomy care orders? ☐ Yes ☐ No Tracheostomy Size: N/A Type: _____
Comments: _____

38. Heart Sounds:

☒ WNL
☐ Murmur
☐ Valvular Click

Pedal Pulses:

☐ Strong
☐ Weak
☐ Absent

Right Left Capillary Refill:
(fingers/toes)

☐ < 3 sec. ☐ > 3 sec

Other: _____

39. (Mark all that apply) ☒ No Problems Reported/Observed

☐ Fatigues Easily ☐ Impaired Circulation ☐ Angina ☐ Syncope ☐ Palpitations
☐ Neck Vein Distention ☐ Varicosities ☐ Other _____

40. Edema: ☒ NA ☐ None observed Last Checked: (date) _____

☐ Non-pitting Parameters: Pitting High _____
Site(s)/Amount (1 - 4+) Low _____

Comments: _____

41. VITAL SIGNS - ☒ At Rest ☐ Post Activity: Type _____ x _____ minutes

Radial Pulse: 68 Respirations: _____ ☒ Unlabored ☐ Labored

Rhythm: ☒ Regular ☐ Irregular

Quality: ☒ Normal ☐ Bounding ☐ Thready

Apical Pulse: _____

Rhythm: ☐ Regular ☐ Irregular

Quality: ☐ Normal ☐ Bounding ☐ Thready

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Blood Pressure: 133/78 ☒ Right ☐ Left Site BP Taken: (R) upper Arm
Temperature: 98.4 ☐ Rectal ☐ Tympanic ☐ Oral ☐ Axillary ☒ Temporal
Weight: 165 lbs. Abdominal Girth: _____ cm Height: _____ ft. _____ in.
Actual Stated BMI: _____ ☐ Actual ☐ Stated
☒ Unable to weigh due to _____ Mid Arm Circumference: _____ cm ☒ Unable to stand
Breath Sounds
Quadrant _____ ☒ Clear ☐ Rhonchi ☐ Rales ☐ Wheezes ☐ Diminished

Elimination Status

42. Urinary Incontinence or ~~Urinary Catheter Presence:~~
☒ No incontinence or catheter (including anuria or ostomy for urinary drainage) (If No-go to # 44)
☐ Patient requires a urinary catheter (i.e., external, indwelling, intermittent, Suprapubic) (Complete next section then go to # 44)
☐ Patient is incontinent

43. Catheter: Initial insertion date: N/A Reason for insertion: _____
Type: (Mark all that apply) Date of last catheter change: _____ / _____ / _____
☐ External ☐ Latex
Indwelling Size: _____ Fr. _____ cc
Suprapubic Catheter Irrigation Orders? ☐ Yes ☐ No
Foley Catheter Insertion/Replacement Orders? ☐ Yes ☐ No
Coude' Comments: _____
Silastic _____

44. Urinary Assessment

Appearance: ☒ Reported ☐ Observed Amount: ☐ Urostomy:
☒ Clear WNL Site: _____
☐ Cloudy Oliguria Appearance: _____
☐ Concentrated Polyuria Appliance type: _____
☐ Hematuria ☐ Anuria
☐ Sediment present

45. (Mark all that apply) ☒ No problems reported
☐ Hesitancy ☐ Urgency ☐ Retention ☐ Other: _____
☐ Frequency ☐ Bladder Distention ☐ Nocturia ☐ Burning _____

46. Bowel Incontinence Frequency: ~~NA Patient has ostomy for bowel elimination (go to # 47)~~
☐ Four to six times weekly ☐ Very rarely or never has bowel incontinence ☐ On a daily basis
☐ Less than once weekly ☐ More often than once daily ☒ One to three times weekly ☐ UK-Unknown

47. Ostomy Assessment: ☒ NA (see #46)
Ostomy Site Location: _____

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Date Ostomy Created: _____ / _____ (mo/yr) *2/17*

Appearance: _____

Type of Appliance: _____

Reason for Ostomy (Diagnosis): _____

Comments: _____

48. Gastrointestinal Assessment: (Mark all that apply) ☐ No Problems Reported/Observed

☐ Hemorrhoids: ☐ External ☐ Internal

☐ Diarrhea

☒ Constipation

☐ Nausea

☐ Vomiting Frequency: _____

☐ Laxatives: Type and Frequency _____

☐ Abdominal Distention Color: _____

☐ Bleeding Date of last BM _____ / _____ / *not sure*

☐ Heartburn

☐ Fecal Impactions Comments: _____

☐ Other: _____

Bowel Sounds ☒ RUQ ☒ LUQ ☒ RLQ ☒ LLQ ☒ WNL ☐ Hypoactive ☐ Hyperactive ☐ Absent

Nutritional Status

49. Nutritional Risk Assessment: (Mark all that apply) (Disciplines in () are suggested consults if checked)

☒ No nutritional risk assessed

☐ Nausea/vomiting (MD) ☐ Wt. Loss/gain of 5-10% body mass ☐ Wound/Post-Surgical (RD)

☐ Diarrhea/constipation (MD) in last 6 mos. (MD/RD) ☐ Drinks 3/ > alc. bev./day (MSW/RD)

☐ Eats 2 or < meals/day (RD/MSW) ☐ Emotional issues/Eating disorder ☐ Limited access to food

☐ Difficulty chewing/swallowing (MSW) or assist. w/preparation physically (RD/SLP)

☐ Takes 3 or > Rx drugs/day (RD/MD) or financially (MSW/RD)

Comments: *not eating much*

50. Nutritional Requirements: (Mark all that apply)

☒ Regular ☐ High Protein ☐ Bland ☐ Enteral

☐ _____ Cal ADA ☐ Restricted Protein _____ Grams ☐ Clear Liquid

☐ _____ Gram Na ☐ High Fiber ☐ Full Liquid _____

☐ No Salt ☐ _____ (Hi/Lo) Carbohydrate ☐ Pureed ☐ Low Fat/Cholesterol

☐ Renal ☐ TPN ☐ Other: _____

*Does patient/caregiver require diet teaching by SN? ☐ Yes ☐ No

Appetite: ☐ Good ☐ Fair ☐ Poor

☐ Supplement(s): _____

Hydration: ☒ Good ☐ Fair ☐ Poor ☐ Fluid restriction: _____ cc/L per _____

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Endocrine Status

51. Endocrine Assessment: (Mark all that apply) ☒ No Problems Reported/Observed

☐ Diabetes: Onset: ☐ Adult ☐ Juvenile Blood Glucose: _____ mg/dl

☐ Diaphoresis ☐ Insulin Dependent ☐ Fasting ☐ Non-fasting

☐ Intolerance of heat/cold ☐ Non-Insulin Dependent Blood Glucose Routinely Performed per:

☐ Excessive thirst/hunger ☐ Diet Controlled * ☐ SN ☐ CG ☐ Pt.

☐ Hyper/Hypothyroidism ☐ Glucometer/AST Frequency: _____

☐ Pituitary Disorders Type: _____ Comments: _____

☐ Pancreatic Disorders Other: _____

Genitalia/Reproductive Status

52. Genitalia/Reproductive Assessment: (Mark all that apply) ☒ Not assessed this visit

☐ Male ☒ Female ☐ No Problems Reported/Observed

☐ Post-Menopausal ☐ Other: _____

Scrotum/Penis: ☐ Not Assessed

Labia/Vagina: ☐ Not assessed

☐ Edema-site _____

☐ Lesions-site _____

☐ Discharge-type _____

☐ Signs of trauma or abuse _____

Comments: _____

Neuro/Emotional/Behavioral Status

53. Neurological Assessment: (Mark all that apply) ☒ No problems Reported/Observed

☐ Altered Balance ☐ Short term memory loss ☐ Catatonia

☐ Long term memory loss ☐ Vertigo ☐ PERRL

Impaired judgment due to: ☐ Seizures ☐ Tremors ☐ Paralysis ☐ Syncope _____

☐ Semi-comatose ☐ Altered Sensation ☐ Dementia ☐ Other: _____

Comments: _____

54. Mental Status: (Mark all that apply)

☒ 1-Oriented (person, place, and time) ☐ 2-Comatose ☐ 3-Forgetful ☐ 4-Depressed ☐ 5-Disoriented

☐ 6-Lethargic ☐ 7-Agitated ☐ 8-Other _____

Comments: _____

55. Psychosocial Assessment: (Mark all that apply) ☐ No Problems Reported/Observed

☒ Coping Difficulties ☐ Hallucinations ☐ Manic Mood ☐ Grief ☐ Paranoia ☐ Depressed Mood

☐ Interpersonal Conflicts ☐ Body Image Distortion ☐ Delusions ☐ Other: _____

Unusual home/social environment that impacts care: _____

Comments: upset regarding current status

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56. Indicators of Physical, Verbal, Sexual Abuse/Neglect (Mark all that apply) ☒ None reported or observed
- ☐ Unusual defense of caretaker ☐ Direct disclosure by patient/other ☐ History of previous/recurrent injury
- ☐ Extreme upset/shame when bathed, toileted, changed ☐ Unnecessary confinement (bed, chair, room)
- ☐ Unusual/unexplained injuries (burns, bruises, bite marks) ☐ Unusual fear/guarding against caretaker
- ☐ Lack of attention to medical/dental needs by caretaker abrasions, lacerations, fractures, etc.
- ☐ Injuries in unusual places-thighs, buttocks, genitals, rectum contributing to weight loss
- ☐ Misuse of patient's funds contributing to poor care ☐ Unsafe/unsanitary conditions in home
- ☐ Meals not prepared or are of poor nutritional quality
- Explain further any findings: _____
- Problems addressed as _____

Musculoskeletal/Functional Status

57. Musculoskeletal Assessment: (Mark all that apply)
- ☐ Ambulatory ☐ Joint Inflammation ☐ FWB
- ☐ Chair bound ☐ Decreased Strength ☐ PWB-Extremity: _____
- ☐ Bedbound ☐ Poor Endurance/Act. Intolerance ☐ NWB-Extremity: _____
- ☐ Moves All Extremities ☐ Furniture Support ☐ Altered Gait: (Describe) _____
- ☐ Limited AROM: (site) _____ Assistive Devices: (list) _____
- ☐ Contractures: (site) _____
- ☐ Amputation: (site) _____
- ☐ Right Handed ☐ Left Handed
- Expand on current ADL/IADL details: (frequency, assistance, equipment/assistive devices used, safety, environment) _____

58. Functional Limitation: (Mark all that apply) ☐ None reported or observed
- ☐ Amputation ☐ Hearing ☒ Ambulation ☐ Dyspnea With Minimal Exertion
- ☐ Bowel/Bladder (incontinence) ☐ Paralysis ☐ Speech ☐ Other (Specify) _____
- ☐ Contracture ☐ Endurance ☐ Legally Blind
- Expand on Functional Limitations and Prior Functional Status, if needed: _____

59. Activities Permitted: (Mark all that apply) ☒ No restriction
- ☐ Complete Bedrest ☐ Transfer Bed/Chair ☐ Independent at Home ☐ Wheelchair
- ☐ Bedrest BRP ☐ Exercises Prescribed ☐ Crutches ☐ Walker
- ☐ Up as Tolerated ☐ Partial Weight Bearing ☐ Cane
- Other: _____

60. Homebound Status: (Mark all that apply) ☐ NA
- Describe items picked in measurable terms as applicable
- ☐ Poor endurance/activity intolerance ☒ Pain (as prescribed in Pain Status Area) ☐ Paranoia
- ☐ Dyspnea with minimal exertion ☐ MD ordered relative to: _____
- ☐ Post-surgical incision/weakness
- ☒ Gait instability ☐ Dementia ☐ Open/draining wound
- ☐ Bedbound due to: _____ ☐ Vertigo/Dizziness
- ☐ Paralysis-location: _____
- ☐ Anxiety _____ Other: _____

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Comprehensive Assessment

61. Specify any known medical and/or non-medical reasons the patient regularly leaves home and frequency of occurrence

☐ MD appointments: frequency as needed ☐ Dialysis-frequency _____

☐ Other: _____

Outpatient Therapy for: ☒ PT-frequency 2-3x/wk ☐ OT-frequency _____

☐ ST-frequency _____ ☐ Psych-frequency _____

62. Management of Medications: Patient's ability to prepare and take all prescribed medications reliably and safely

☐ NA-No oral medications prescribed

☐ Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

☒ Able to take medication(s) at the correct times if:

☒ individual dosages are prepared in advance by another person, OR

☐ given daily reminders, OR

☐ someone develops a drug diary or chart,

☐ Unable to take medication unless administered by someone else.

63. Is patient taking any inhalation treatments or medications?

☐ Yes ☒ No

Who will manage inhalation treatments? ☐ Patient ☐ Caregiver ☐ SN

☐ Other: _____

64. Is patient taking any injectable medications? ☐ Yes ☒ No

Who will administer injectable medications? ☐ Patient ☐ Caregiver ☐ SN

☐ Other: _____

65. Does patient have any new or changed medications that require teaching by SN?

☐ Yes ☒ No

66. Is patient on any medications that require SN to perform Venipuncture to monitor therapeutic levels?

☐ Yes ☒ No

List medication(s)/comments: _____

67. Equipment NONE

DME Company: _____

Phone/Fax: _____

Current DME items: walker

DME Needs: _____

68. Does the patient/caregiver need DME assistance or training?

☐ Yes ☒ No

69. Patient Management of Equipment/supplies: Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medications, clean/store/dispose of equipment or supplies

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using proper technique

☐ NA-No equipment of this type used in care.

☒ Patient manages all tasks related to equipment completely independently.

☐ If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment.

☐ Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.

☐ Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.

☐ Patient is completely dependent on someone else to manage all equipment.

70. Narrative Summary: (Summary of Patient's History, Problems, Needs, and Strengths)

Client is a 69 year old woman with recent hospitalization for R knee replacement/revision. Surgical site has 25 staples. No drainage or signs/symptoms of infection. Reports pain is 5/10 at this time. Pain managed with Oxycodone-Acetaminophen 5/325. Ambulates with unsteady gait. Walker used at this time. At risk for falls 2° to pain. Currently receives assistance from family. Also reports anxiety 2° to current status and the time it is taking to recover. Receives Clonazepam B.I.D. Appetite is fair; not sure when she had her last bowel movement. Encouraged to drink plenty of fluids and to monitor bowel movements. Family is very supportive.

71. Skill performed this visit (Including patient/family education):

Nursing ^W
Patient evaluation and education

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72. Patient/Caregiver Response to Teaching/Intervention:

acknowledged understanding

73. Supplies Used This Visit: (list supplies or attach supply sheet)

N/A

74. Orders for discipline and Treatments (Specify Amount/Frequency/Duration; Include lab orders):

Frequencies:

Skilled Nurse: *1-2 x/wk*

Home Care Aide: _____

Physical Therapy: *2-3 x/wk*

Occupational Therapy: _____

Speech Therapy: _____

MSW: _____

75. Orders:

Skilled Nursing 1-2 x/wk
Physical therapy 2-3 x/wk

76. Goals:

① *Surgical wound @ knee will show no s/s of infection*

② *Surgical wound will heal w/ complications*

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77. Rehabilitation Potential: ☒ Good ☐ Fair ☐ Poor

Due to: Above stated orders and goals Other: _____

78. Discharge Plans:

Patient will be discharged to:

☐ Self-care ☐ Family ☐ Caregiver ☐ Extended Care Facility

Patient will be discharged when able to:

☒ Meet stated goals

Other: _____

79. Date physician last saw patient: 5/24/15

Reason for provider contact: D/C from hospital

Patient Signature: *Samuel Gustave* Date: 5-30-15

Nurse Signature: *Linda Worthington RSN* Date: 5-30-15

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77. Rehabilitation Potential: ☒ Good ☐ Fair ☐ Poor

Due to: Above stated orders and goals Other: _____

78. Discharge Plans:

Patient will be discharged to:

☐ Self-care ☐ Family ☐ Caregiver ☐ Extended Care Facility

Patient will be discharged when able to:

☒ Meet stated goals

Other: _____

79. Date physician last saw patient: 5/24/15

Reason for provider contact: D/C from hospital

Patient Signature: *Samuel Gustave* Date: 5-30-15

Nurse Signature: *Linda Worthington RSN* Date: 5-30-15

Carelink Health Care Services, LLC

Nursing Visit Record

Pamela Justiniano
Patients Name

6094077695-1
Medical Record Number

Allergies: UKDA

Medication change since last visit? ☒ No ☐ Yes, Specify

Homebound? ☒ No ☐ Yes (If yes, reason)

Patient Lives - ☐ Alone, ☒ With Family, ☐ Non Relative

VITAL SIGNS	RESPIRATORY	SKIN	GU	CARDIOVASCULAR
- Temp: <u>98.1</u> - Pulse: <u>68</u> - Resp: <u>20</u> - Wt: _____ - BP: _____ - right _____ - left <u>120/80</u> - Extremity Pulses _____ - Glucometer _____ - BS: _____ - Universal _____ - Precautions _____ - Maintained _____	☒ No Deficit ☐ Rale/Rhonchi ☐ SOB ☐ Cough ☐ Sputum ☐ O2 at _____ ☐ O2Sat _____ ☐ Other _____ - Comments: <u>Clear</u>	- Edema Location <u>0</u> TR 1+ 2+ 3+ 4+ ☐ Non Pitting ☐ Pitting ☐ No Deficit ☐ Cool/Clammy ☐ Warm/Dry ☐ Turgor Adequate 1st Wound Location <u>healed</u> 2nd Wound Location _____ - L <u>Surgical</u> - W <u>wound</u> - D <u>at knee</u> - DRAINAGE _____ - Amt <u>steri</u> - Color <u>strips</u> - Odor _____	☒ No Deficit ☐ Distention ☐ Retention ☐ Burning ☐ Frequency ☐ Foley cath ☐ Suprapubic ☐ Incontinence - Size _____ F - ml _____ - Comments: _____	☒ No Deficit ☐ Chest Pain ☐ Heart Sounds <u>regular</u> ☐ Peripheral Pulses ☐ Dizziness ☐ Edema ☐ Neck Vein Distention ☐ Arrhythmia - Comments: _____

MUSCULOSKELETAL	NEUROLOGICAL	DIGESTIVE/NUTRITION	PAIN
☐ No Deficit ☐ Weakness ☐ Balance/Gait Abnormal ☐ Limited Mobility/ROM ☒ Pain <u>at knee, back</u> ☐ Grip Strength _____ - right _____ - left _____ - Bed bound _____ - Chair bound _____ - Contracture _____ - Paralysis _____ ☒ Assistive/Device - Fall Precautions maintained <u>Care</u> <u>walker</u>	☒ No Deficit ☐ Oriented to Person / Place / Time ☐ Seizure/Tremors ☐ Pupillary Reaction Right/Left/Equal - SENSORY <u>N/A</u> ☐ Hearing Impaired ☐ Speech Impaired ☐ Visually Impaired ☐ Legally Blind	☐ No Deficit - Last BM <u>6/9/15</u> ☐ N/V ☐ Diarrhea ☐ Constipation ☐ Tube Feeding ☐ NPO Type/Amount _____ ☐ Placement ☐ Residual/Amt. _____ ☐ Bowel Sounds Present ☐ Abd. Girth _____ ☒ Diet <u>Regular</u> ☐ Meals Prepared & Administered Appropriately ☐ Past 24-Hour Diet Recall ☐ Adequate ☐ Inadequate	- Frequency of Pain interfering with patient's activity or movement: ☐ 0 - Patient has none or pain doesn't interfere with activity or movement ☐ 1 - Less than daily ☐ 2 - Daily, but not constantly ☒ 3 - All of the time - PAIN PROFILE <u>throbbing, very sensitive</u> - Primary Site: <u>lower back "lock s"</u> - Intensity <u>at knee</u> 0 1 2 3 4 5 6 7 8 9 10 - low high - Current pain management & effectiveness: <u>Just took medication</u> - Pain Management Teaching to patient/family (document below) - Patients pain goal: <u>no pain</u> - Progress toward pain goal: _____

Reason for visit:

f/u with client; Surgical wound on
at knee S/P Revision of TKR. Sutures removed.
Surgical site healing, @ s/s infection. Reports she
continues to have pain constantly but is managed
with medication. Ambulates with a limp; favors
at LE. Uses the walker on a cane

☐ LPN

☐ Aide

Present on this visit? Yes No

Aide following care plan? Yes No

Courteous and polite? Yes No

Report changes in status? Yes No

Patient satisfied with care? Yes No

Changes made to care plan? Yes No

Additional instruction given? Yes No

Patient response to care:

Sutures removed 6-8-15; f/u 6-15-15

Progress toward goals:

Surgical wound healed

Teaching Tools used/given:

☒ Instructed ☐ Pt/Cg. Verbalized Understanding ☐ Pt/Cg. Return Demonstration

Conference with: SN PT OT SLP MSS HHA (circle one) Name: _____

Regarding: _____

Plan for Next Visit: _____

Patient Signature

Nurse Signature & Title

Time In

Time Out

Date

Date

☐ Nursing Supervisor Review

Supervisor Name

Supervisor Signature

RECEIVED JUN 12 2015

Nursing Visit Record

Patients Name _____

Pamela Testimano

6094077695-1

Medical Record Number

OBSERVATION

Allergies:

Medication change since last visit? ☒ No ☐ Yes, Specify _____Homebound? ☐ No ☐ Yes (If yes, reason)Patient Lives - ☐ Alone, ☒ With Family, ☐ Non Relative

VITAL SIGNS	RESPIRATORY	SKIN	GU	CARDIOVASCULAR
- Temp: <u>98°</u> - Pulse: <u>99</u> - Resp: <u>20</u> - Wt: <u>167</u> - BP: <u>134/89</u> right <u>left</u> - Extremity Pulses - Glucometer BS: _____ - Universal Precautions Maintained	☒ No Deficit ☐ Rale/Rhonchi ☐ SOB ☐ Cough ☐ Sputum ☐ O2 at _____ ☐ O2Sat _____ ☐ Other _____ - Comments: _____ _____ _____ _____	- Edema Location _____ TR 1+ 2+ 3+ 4+ ☒ Non Pitting ☐ Pitting ☐ No Deficit ☐ Warm/Dry ☐ Cool/Clammy ☐ Turgor Adequate 1st Wound Location <u>@ knee</u> 2nd Wound Location _____ - L <u>Surgical</u> - W <u>Site</u> - D <u>healed</u> - DRAINAGE - Amt _____ - Color _____ - Odor _____	☒ No Deficit ☐ Distention ☐ Retention ☐ Burning ☐ Frequency ☐ Foley cath ☐ Suprapubic ☐ Incontinence - Size _____ F _____ ml - Comments: _____ _____ _____	☒ No Deficit ☐ Chest Pain ☐ Heart Sounds ☐ Peripheral Pulses ☐ Dizziness ☐ Edema ☐ Neck Vein Distention ☐ Arrhythmia - Comments: _____ _____ _____

MUSCULOSKELETAL	NEUROLOGICAL	DIGESTIVE/NUTRITION	PAIN
- No Deficit - Weakness <i>2° pain</i> - Balance/Gait Abnormal - Limited Mobility/ROM - Pain - Grip Strength right _____ left _____ - Bed bound - Chair bound - Contracture - Paralysis - Assistive/Device - Fall Precautions maintained	- No Deficit - Oriented to Person / Place / Time - Seizure/Tremors - Pupillary Reaction Right/Left/Equal SENSORY <i>N/A</i> - Hearing Impaired - Speech Impaired - Visually Impaired - Legally Blind	- No Deficit – Last BM <i>6/19/15</i> - N/V - Diarrhea - Constipation - Tube Feeding - NPO Type/Amount _____ - Placement - Residual/Amt. _____ - Bowel Sounds Present <i>x 4</i> - Abd. Girth - Diet <i>Regular</i> - Meals Prepared & Administered Appropriately - Past 24-Hour Diet Recall - Adequate - Inadequate	Frequency of Pain interfering with patient's activity or movement: 0 - Patient has none or pain doesn't interfere with activity or movement 1 - Less than daily 2 - Daily, but not constantly 3 - All of the time <i>@ Knee - throbbing, sharp</i> PAIN PROFILE Primary Site: <i>lower back throbbing</i> Intensity low 0 1 2 3 4 <i>5</i> 6 7 8 9 10 high Current pain management & effectiveness: <i>Percocet Q 6°</i> Pain Management Teaching to patient/family (document below) Patients pain goal: <i>0 pain</i> Progress toward pain goal: <i>(+4 5 taking medication</i>

INTERVENTION

SUPERVISION

Reason for visit:	f/u with patient for surgical revision of R knee. Surgical wound is healed. No S/S of ~~post~~ infection. Continues to have pain in R knee and in lower back. Pain management in place. At risk for constipation. fluids encouraged, encouraged to monitor bowel movements		o LPN	
			o Aide	
	Present on this visit?	Yes	No	
	Aide following care plan?	Yes	No	
	Courteous and polite?	Yes	No	
	Report changes in status?	Yes	No	
	Patient satisfied with care?	Yes	No	
	Changes made to care plan?	Yes	No	
	Additional instruction given?	Yes	No	
Patient response to care:	Improvement			

GOALS / PLAN

Progress toward goals: _____
 Teaching Tools used/given: _____ ☒ Instructed ☒ Pt/Cg. Verbalized Understanding ☐ Pt/Cg. Return Demonstration
 Conference with: SN PT OT SLP MSS HHA (circle one) Name: _____ Regarding: _____
 Plan for Next Visit: _____

Patient Signature _____

Nurse Signature & Title

Time In

Time Out

Date _____

☐ Nursing Supervisor Review

Supervisor Name _____

Supervisor Signature _____

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Carelink Health Care Services, LLC
Narrative/Progress Therapy Note

Patient Name (Last, First) please print Pamela Justiniano		Patient Signature: <i>Pamela Justiniano</i>	
Therapist Name (Last, First) please print <i>Eugene Ogutue</i>		Miles	Time In 9:12
Discipline PT OT ST		Time Out 10:01	
Type ☐ Evaluation ☐ Re-Evaluation ☐ Supervisory ☒ Discharge ☐ Routine ☐ 30 Day Summary ☐ 90 Day Summary		Date: 6/30/15	

Narrative/Progress:

patient is able to ambulate independently using a straight cane. Analgesic given.
Transfer sit → stand independently but sometimes difficult after a prolonged sitting. ✓
Reduced tenderness at the (R) knee & low back.
Dynamic Balance is Fair+.
Muscle strength is 3+/5 grossly throughout.
She has progress to outpatient, therefore she's discharged from home care.

Reason Patient Remains Homebound: (Must Check One or More)

- | | | | |
|-------------------------------------|--------------------------------------|-----------------------------------|---------------------------------------|
| ☐ Ambulation | ☐ Mobility | ☐ Strength | ☐ ROM |
| ☐ Endurance | ☐ Respiratory | ☐ Balance | ☐ Other: _____ |

Therapist Signature: *E. Ogutue*
☒ Day Discharge Notice Given

Date: **6/30/15**

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