

Carelink Health Care Services, LLC
Comprehensive Assessment

Patient Name: _____ MR#: _____
Date: _____ Time In: _____ Time Out: _____

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: _____ 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: _____ 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 the apply)

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

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

Most Recent Facility Name: _____ Dates of stay: _____ to _____

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: _____

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 _____ / _____ (Mo/Yr)

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

☐ Other: _____ / _____ (Mo/Yr)

Comments: _____

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9. Screening: (Mark all that apply) ☐ Female ☐ Male ☐ NA-no screening tests
☐ Mammogram ____/____ (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-10 code.

Primary Diagnosis ICD-10-CM Onset/Exacerbation Date

a. _____ (____.____) O E _____

Other Diagnosis

b. _____ (____.____) O E _____

c. _____ (____.____) O E _____

d. _____ (____.____) O E _____

e. _____ (____.____) O E _____

f. _____ (____.____) O E _____

Additional Diagnoses ICD-10-CM Onset/Exacerbation Date

_____ (____.____) O E _____

_____ (____.____) O E _____

_____ (____.____) O E _____

_____ (____.____) O E _____

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

Procedure ICD-10-CM Date Performed

1. _____ (____.____)

2. _____ (____.____)

Surgical History: _____

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

- ☐ 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)

- ☐ 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)

☐ 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: _____

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: _____

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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: _____

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	Gums/Oral Mucosa	Lips	Tongue
☐ Natural Teeth	☐ Pink	☐ Pink	☐ Pink
☐ Dentures	☐ Pale	☐ Pale	☐ Pale
☐ Partial/Bridge	☐ Moist	☐ Cyanotic	☐ Moist
☐ Edentulous	☐ Dry	☐ Moist	☐ Edema
☐ Chewing Problems	☐ Edema	☐ Dry	☐ Protrusion
☐ Bleeding	☐ Bleeding	☐ Cracked	☐ 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:

				<u>Intensity</u>							
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: _____

Current Relief Methods Oral meds, ice, elevation, other _____

Goal: (0-10) _____ Comments: _____

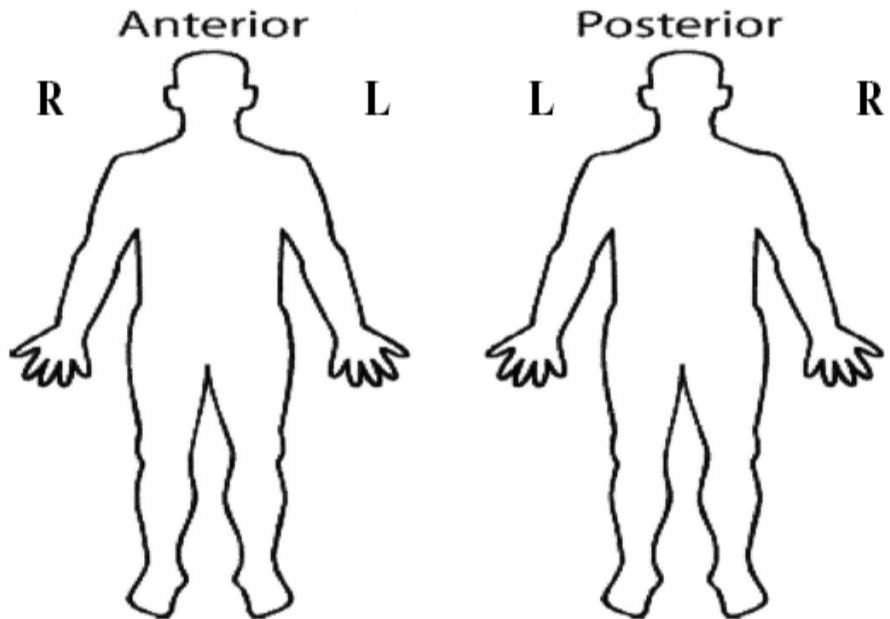
Integumentary Status

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

☐Yes ☐No

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: _____

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: _____ 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: _____ 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: _____ ☐Right ☐Left Site BP Taken: _____

Temperature: _____ ☐Rectal ☐Tympanic ☐Oral ☐Axillary ☐Temporal

Weight: _____ 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: _____ 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)

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 ____/____/_____

☐ 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: _____

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: _____

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

☐MD appointments: frequency_____ ☐Dialysis-frequency_____

☐Other:_____

Outpatient Therapy for: ☐PT-frequency_____ ☐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:_____

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)

This image shows a single page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page, leaving small margins at the top and bottom. There is no handwriting or other markings on the paper.

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

[illegible]

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72. Patient/Caregiver Response to Teaching/Intervention:

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

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

Frequencies:

Skilled Nurse: _____ Home Care Aide: _____

Physical Therapy: _____ Occupational Therapy: _____

Speech Therapy: _____ MSW: _____

75. Orders:

76. Goals:

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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: ____/____/____

Reason for provider contact: _____

Patient Signature: _____ Date: _____

Nurse Signature: _____ Date: _____