PROFESSIONAL SERVICES WORKSHEET with SUMMARY CHECKLIST

Patient Name_____ ID #_____

UTILIZE THIS FORM TO ASSIST WITH COMPLETION OF PLAN OF CARE

SN - FREQUENCY/DURATION _____
- ❑ Skilled Observation for
- ❑ Evaluate Cardiopulmonary Status
- Evaluate: ❑ Nutrition ❑ Hydration ❑ Elimination
- ❑ Evaluate for S/S of Infections
- ❑ Teach Disease Process
- ❑ Teach S/S of Infection and Standard Precautions
- ❑ Teach Diet
- Teach: ❑ Home Safety ❑ Falls Prevention
- ❑ Other_____
- ❑ PRN Visits for_____
- ❑ Psychiatric Nursing for_____

MEDICATIONS
- ❑ Medication Teaching
- ❑ Evaluate Med Effects ❑ Compliance
- ❑ Set up Meds Every _____ ❍ Days ❍ Weeks
- ❑ Administer Medication(s) (name, dose, route, frequency)
- ❑ Administer Medication(s) (name, dose, route, frequency)
- ❑ Administer Medication(s) (name, dose, route, frequency)

IV
- ❑ Administer IV Medication (name, dose, route, frequency and duration)
- ❑ Teach IV Administration_____

FLUSHING PROTOCOL/ FREQUENCY (specify)
- ❑ Administer Flush(es) _____
- ___mL normal saline _____
- ___mL normal saline _____
- ___mL sterile water _____
- ___mL heparin ___unit/mL
- ___mL heparin ___unit/mL
- ❑ Teach S/S of IV Complications
- ❑ Teach IV Site Care
- ❑ Teach Infusion Pump
- ❑ Teach Complete Parenteral Nutrition
- ❑ Site Care (specify)_____
- ❑ Line Protocol (specify)
- ❑ ____ PRN Visits for IV Complications
- ❑ Anaphylaxis Protocol (specify orders)
- ❑ Other_____

RESPIRATORY
- ❑ O_2 at _____ liters per minute
- ❑ Pulse Oximetry: Every Visit
- ❑ Pulse Oximetry: PRN Dyspnea
- Teach: ❑ Oxygen Use ❑ Oxygen Precautions
- ❑ Teach Trach Care ❑ Administer Trach Care
- ❑ Other_____

INTEGUMENTARY
- ❑ Wound Care (specify each site)
- ❑ Evaluate Wound(s) ❑ Pressure Ulcer/Injury for Healing(s)
- ❑ Measure Wound(s) Weekly
- ❑ Teach Wound Care ❑ Dressing
- ❑ Other_____

ELIMINATION
- ❑ Catheter _____ French inflated balloon(s) with _____mL changed every_____
- ❑ Suprapubic Cath Insertion every_____ with size _____Fr. balloon_____
- ❑ Teach Care of Indwelling Catheter
- ❑ Teach Self - Cath ❑ Teach Ostomy Care
- ❑ Teach Bowel Regimen
- ❑ Other_____

GASTROINTESTINAL
- ❑ Teach N/G Tube Feeding
- ❑ Teach G-Tube Feeding
- ❑ Other_____

DIABETES
- ❑ Administer Medication
- ❑ Prepare Insulin Syringes
- ❑ Blood Glucose Monitoring PRN or _____
- ❑ Teach Diabetic Care
- ❑ Other_____

LABORATORY
- ❑ Venipuncture for_____ Frequency_____
- ❑ Other

PT - FREQUENCY/DURATION_____
- ❑ Evaluation and Treatment
- ❑ Pulse Oximetry PRN
- ❑ Home Safety ❑ Falls Prevention
- ❑ Therapeutic Exercise
- ❑ Transfer Training
- ❑ Gait Training
- ❑ Establish Home Exercise Program
- ❑ Modality (specify frequency, duration, (amount)
- ❑ Prosthetic Training
- ❑ Muscle Re-Education
- ❑ Other_____

OT - FREQUENCY/DURATION_____
- ❑ Evaluation and Treatment
- ❑ Pulse Oximetry PRN
- ❑ Home Safety ❑ Falls Prevention
- ❑ Adaptive Equipment
- ❑ Therapeutic Exercise
- ❑ Muscle Re-Education
- ❑ Establish Home Exercise Program
- ❑ Homemaker Training
- ❑ Modality (specify frequency, duration, (amount)
- ❑ Other_____

SLP - FREQUENCY/DURATION _____
- ❑ Evaluation and Treatment
- ❑ Voice Disorder Treatment
- ❑ Speech Articulation Disorder Treatment
- ❑ Dysphagia Treatment
- ❑ Receptive Skills
- ❑ Expressive Skills
- ❑ Cognitive Skills
- ❑ Other_____

HOME HEALTH AIDE - FREQUENCY/ DURATION_____
- ❑ Personal Care for ADL Assistance
- ❑ Other (specific task for HHA)

HOMEMAKER - FREQUENCY/DURATION_____
- ❑ Other

MSW - FREQUENCY/DURATION_____
- ❑ Evaluate and Treat
- ❑ Evaluate Family Situation
- ❑ Evaluate ❑ Refer for Community Resources
- ❑ Evaluate Financial Status
- ❑ Other_____

PROFESSIONAL SERVICES WORKSHEET with SUMMARY CHECKLIST

REHABILITATION/POTENTIAL GOALS WORKSHEET

DISCIPLINE GOALS AND DATE WILL BE ACHIEVED - Check goal(s) and insert information. Indicate short or long-term goal(s).

Nursing:

❑ Demonstrates compliance with medication by _____ (date). ❍ Short ❍ Long

❑ Stabilization of cardiovascular pulmonary condition by _____ (date). ❍ Short ❍ Long

❑ Demonstrates competence in following medical regimen by _____ (date). ❍ Short ❍ Long

❑ Verbalizes pain controlled at acceptable level by _____ (date). ❍ Short ❍ Long

❑ Demonstrates independence in _____ by _____ (date). ❍ Short ❍ Long

❑ Verbalizes ❑ Demonstrates independence with care by _____ (date). ❍ Short ❍ Long

❑ Wound healing without complications by _____ (date). ❍ Short ❍ Long

❑ Expect daily SN visits to end by _____ (date). ❍ Short ❍ Long

❑ Other:_____ by _____ (date). ❍ Short ❍ Long

Physical Therapy:

❑ Demonstrates ability to follow home exercise program by _____ (date). ❍ Short ❍ Long

❑ Other:_____ by _____ (date). ❍ Short ❍ Long

Occupational Therapy:

❑ Demonstrates ability to follow home exercise program by _____ (date). ❍ Short ❍ Long

❑ Other:_____ by _____ (date). ❍ Short ❍ Long

Speech Therapy:

❑ Demonstrate swallowing skills in ❑ formal ❑ informal dysphagia evaluation exercise program by _____ (date). ❍ Short ❍ Long

❑ Completes speech therapy program by _____ (date). ❍ Short ❍ Long

❑ Other:_____ by _____ (date). ❍ Short ❍ Long

Aide:

❑ Assumes responsibility for personal care needs by _____ (date). ❍ Short ❍ Long

❑ Other:_____ by _____ (date). ❍ Short ❍ Long

Medical Social Services:

❑ Verbalize information about community resources and how to obtain assistance by _____ (date). ❍ Short ❍ Long

❑ Other:_____ by _____ (date). ❍ Short ❍ Long

SUMMARY CHECKLIST

CARE PLAN: ❑ Reviewed ❑ Revised with ❑ Patient ❑ Representative involvement ❑ Outcome achieved

MEDICATION STATUS: ❑ Medication regimen completed/reviewed ❍ No change ❍ Order obtained

Check if any of the following were identified: ❑ Potential adverse effects ❑ Drug reactions ❑ Ineffective drug therapy ❑ Significant side effects ❑ Significant drug interactions ❑ Duplicate drug therapy ❑ Non-compliance with drug therapy

CARE COORDINATION: ❑ Certifying Physician ❑ SN ❑ PT ❑ OT ❑ SLP ❑ MSW ❑ Aide ❑ Other (specify):_____

Was a referral made to MSW for assistance with: ❑ Community resources ❑ Living will ❑ Counseling needs ❑ Unsafe environment

❑ Other:_____

Date:_____ ❍ Yes ❍ No ❍ Refused ❍ N/A Comment:_____

REFERRAL TO:_____

REASON FOR REFERRAL:_____

APPROXIMATE NEXT VISIT DATE:_____ **PLAN FOR NEXT VISIT:**_____

RECERTIFICATION: ❍ No, complete discharge summary ❍ Yes, complete recertification as appropriate

Document the reason(s)/medical necessity that supports the continuation/recertification of services:

_____

Verbal Order obtained: ❍ No ❍ Yes, specify date:_____

REHABILITATION POTENTIAL/ANTICIPATED DISCHARGE FOR PLAN OF CARE

❍ Return to an independent level of care (self-care)

❍ Able to remain in residence with assistance of: ❑ Primary caregiver ❑ Support from community agencies

❍ Restorative Potential, based on clinical objective assessment and evidence based knowledge supports the patient's condition is likely to undergo functional improvement and benefit from rehabilitative care

Discussed discharge plan with: ❑ Patient ❑ Representative ❑ Other:_____

List any changes since last assessment:

OASIS INFORMATION

Signature of Person Completing Form:_____ **Date:**_____