COMPREHENSIVE ADULT ASSESSMENT

DATE OF VISIT _____

TIME IN _____ **OUT** _____

PATIENT HISTORY

Patient Name **(Locator #6)** _____ ❍ Male ❍ Female **(Locator #9)**

Patient Address _____

Date of Birth **(Locator #8)** _____

MR Number **(Locator #4)** _____

S.O.C. Date **(Locator #2)** _____

Certification Period **(Locator #3)** _____

Health Insurance Claim # **(Locator #1)** _____

Primary Diagnosis (ICD Code) **(Locator #11)** (_____ . _____) Date _____ ❍ O ❍ E

Secondary Diagnosis (ICD Code) **(Locator #13)** (_____ . _____) Date _____ ❍ O ❍ E

(_____ . _____) Date _____ ❍ O ❍ E

(_____ . _____) Date _____ ❍ O ❍ E

(_____ . _____) Date _____ ❍ O ❍ E

(_____ . _____) Date _____ ❍ O ❍ E

PERTINENT BACKGROUND INFORMATION

PHYSICIAN: Date last contacted _____ Date last visited _____

PRESENT ILLNESS: _____

PRIMARY REASON FOR HOME CARE: _____

RECENT HOSPITALIZATION? ❍ No ❍ Yes, dates _____ – _____

Reason: _____

New diagnosis/condition? ❍ No ❍ Yes, specify _____

PRIOR HOSPITALIZATION(S)? ❍ No ❍ Yes, Number of times _____

Reason(s)/Date(s) _____

PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES

❑ Hypertension ❑ Cardiac ❑ Diabetes ❑ Respiratory ❑ Osteoporosis ❑ Fractures

❑ Cancer (site: _____) ❑ Infection ❑ Immunosuppressed ❑ Open Wound

❑ Surgeries: _____ ❑ Other: _____

IMMUNIZATIONS ❑ Up-to-date

Needs: ❑ Influenza ❑ Pneumonia ❑ Tetanus ❑ Other (specify) _____

LIVING ARRANGEMENTS/CAREGIVER INFORMATION

❑ House ❑ Apartment ❑ New environment

❑ Family present ❑ Lives alone ❑ Lives w/others

Primary caregiver (name) _____

Relationship/Health status _____

❑ Assists with ADLs ❑ Provides physical care

❑ Other (specify) _____

❑ Secondary/Other caregivers (describe) _____

EYES/EARS

EYES

❑ Glasses ❑ Glaucoma ❑ Jaundice

❑ Contacts: ❑ **R** ❑ **L** ❑ Blurred vision ❑ Ptosis

❑ Prosthesis: ❑ **R** ❑ **L** ❑ Legally blind

❑ Infections _____

❑ Cataract surgery: **Site** _____ **Date** _____

❑ Other (specify including history) _____

❑ **NO PROBLEM**

EARS

❑ HOH: ❑ **R** ❑ **L** ❑ Deaf: ❑ **R** ❑ **L** ❑ Hearing aid: ❑ **R** ❑ **L**

❑ Vertigo ❑ Tinnitus

❑ Other (specify including history) _____

❑ **NO PROBLEM**

ALLERGIES

ALLERGIES: **(Locator #17)**

❑ None known ❑ Aspirin ❑ Sulfa

❑ Pollen ❑ Penicillin ❑ Eggs

❑ Milk products ❑ Insect bites

❑ Other _____

ADVANCE DIRECTIVES

❑ Living will

❑ Do not resuscitate

❑ Organ donor

❑ Education needed

❑ Copies on file

❑ Funeral arrangements made

Comments: _____

Teaching/Instructions: _____

PROGNOSIS **(Locator #20)**

❍ 1-Poor ❍ 2-Guarded ❍ 3-Fair

❍ 4-Good ❍ 5-Excellent

NOSE/THROAT/MOUTH

NOSE

❑ Congestion ❑ Epistaxis

❑ Loss of smell ❑ Sinus prob.

❑ Other (specify, including history)

_____

_____

_____ ❑ **NO PROBLEM**

THROAT

❑ Dysphagia ❑ Hoarseness

❑ Lesions ❑ Sore throat

❑ Other (specify, including history)

_____

_____

_____ ❑ **NO PROBLEM**

MOUTH

❑ Dentures: ❑ Upper ❑ Lower ❑ Partial ❑ Masses/Tumors

❑ Gingivitis ❑ Ulcerations ❑ Toothache

❑ Other (specify, including history) _____

_____

_____ ❑ **NO PROBLEM**

HEAD/NECK

❑ Headache (❑ see Neuro/Emotional/Behavior status)

❑ Injuries/Wounds (❑ see Skin Condition/Wound section)

❑ Masses/Nodes: **Site** _____ **Size** _____

❑ Alopecia _____

❑ Other (specify, including history) _____

_____ ❑ **NO PROBLEM**

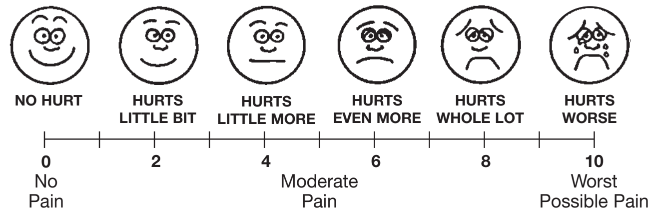
PATIENT NAME – Last, First, Middle Initial	ID#

Patient Name______________________________ ID #____________________

PAIN

Intensity: (using scales below)

Wong-Baker FACES Pain Rating Scale



**From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Collected using: ❍ **FACES Scale** ❍ **0-10 Scale (subjective reporting)**

Pain Assessment	Site 1	Site 2	Site 3
Location			
Onset			
Present level (0-10)			
Worst pain gets (0-10)			
Best pain gets (0-10)			
Pain description (aching, radiating, throbbing, etc.)			

❑ **No Problem**

Is patient experiencing pain? ❍ Yes ❍ No

❑ Unable to communicate

Non-verbals demonstrated: ❑ Diaphoresis ❑ Grimacing ❑ Moaning ❑ Crying ❑ Guarding ❑ Irritability ❑ Anger ❑ Tense ❑ Restlessness ❑ Change in vital signs ❑ Other:_____________ ❑ Self-assessment ❑ Implications: _______________________

Frequency: ❍ Occasionally ❍ Continuous ❍ Intermittent ❍ Other:__________

What makes pain worse? ❑ Movement ❑ Ambulation ❑ Immobility ❑ Other:__________

What makes pain better? ❑ Heat ❑ Ice ❑ Massage ❑ Repositioning ❑ Rest/Relaxation ❑ Medication ❑ Diversion ❑ Other:__________

How often is breakthrough medication needed?
❍ Never ❍ Less than daily ❍ 2-3 times/day ❍ More than 3 times/day

Current pain control medications adequate: ❍ Yes ❍ No ❑ Other:__________

Implications Care Plan: ❍ Yes ❍ No

ENDOCRINE/HEMATOLOGY

(Check all applicable items)

❑ Diabetes: ❍ Type 1 ❍ Type 2 ❍ Other__________

❑ Diabetic Diet Medication(s): ❑ Oral ❑ Injectable

❑ Hyperglycemia: ❑ Glycosuria ❑ Polyuria ❑ Polydipsia

❑ Hypoglycemia: ❑ Sweats ❑ Polyphagia ❑ Weak ❑ Faint ❑ Stupor

❑ Blood sugar range__________ ❑ Patient ❑ Caregiver Report

❑ Who performs blood sugars ❑ Self ❑ RN ❑ Caregiver/family ❑ Other__________

❑ Thyroid ❑ Fatigue ❑ Intolerance to heat ❑ Intolerance to cold ❑ Other__________

❑ Anemia (specify if known) __________

❑ Secondary bleed: ❑ GI ❑ GU ❑ GYN ❑ Unknown ❑ Hemophilia ❑ Other__________

❑ **NO PROBLEM**

SKIN CONDITION/WOUNDS

WOUND/LESION (specify)	#1	#2	#3	#4	#5
Location					
Type:	❍ Diabetic ulcer ❍ Pressure ulcer ❍ Venous stasis ulcer ❍ Arterial ulcer ❍ Traumatic wound ❍ Burn wound ❍ Surgical wound ❍ Other (specify)______	❍ Diabetic ulcer ❍ Pressure ulcer ❍ Venous stasis ulcer ❍ Arterial ulcer ❍ Traumatic wound ❍ Burn wound ❍ Surgical wound ❍ Other (specify)______	❍ Diabetic ulcer ❍ Pressure ulcer ❍ Venous stasis ulcer ❍ Arterial ulcer ❍ Traumatic wound ❍ Burn wound ❍ Surgical wound ❍ Other (specify)______	❍ Diabetic ulcer ❍ Pressure ulcer ❍ Venous stasis ulcer ❍ Arterial ulcer ❍ Traumatic wound ❍ Burn wound ❍ Surgical wound ❍ Other (specify)______	❍ Diabetic ulcer ❍ Pressure ulcer ❍ Venous stasis ulcer ❍ Arterial ulcer ❍ Traumatic wound ❍ Burn wound ❍ Surgical wound ❍ Other (specify)______
Size (cm) (LxWxD)					
Stage (pressure ulcers only)					
Tunneling/ Undermining					
Odor					
Surrounding Skin					
Edema					
Stoma					
Appearance of the Wound Bed					
Drainage/Amount	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large
Color	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other
Consistency	❍ Thin ❍ Thick	❍ Thin ❍ Thick	❍ Thin ❍ Thick	❍ Thin ❍ Thick	❍ Thin ❍ Thick

Patient Name_____ ID #_____

SKIN CONDITION / WOUNDS (Cont'd.)

Skin (temperature, color, turgor)_____ ❑ WNL

Wound care performed: ❍ Yes ❍ No Location(s) if patient has more than one wound site:_____

❑ Soiled dressing removed By: ❑ Patient ❑ Family/caregiver ❑ RN/PT

❑ Wound cleaned with (specify):_____

❑ Wound irrigated with (specify):_____

❑ Wound packed with (specify):_____

❑ Wound dressing applied (specify):_____

❑ Patient tolerated procedure well

❑ Other (specify):_____

Satisfactory return demo: ❍ Yes ❍ No Education: ❍ Yes ❍ No

CARDIOPULMONARY

This section completed in accordance with organizational policy.
(Check all applicable items) **Height**_____ **Weight**_____

Blood Pressure: ❑ Sitting ❑ Lying R_____ L_____
❑ Standing R_____ L_____

Temperature:_____ ❍ Oral ❍ Axillary ❍ Rectal ❍ Tympanic

Pulse: ❑ Apical_____ ❑ Brachial_____ ❍ Regular ❍ Irregular
❑ Radial_____ ❑ Carotid_____ ❑ Rest ❑ Activity

Heart Sounds: ❍ Regular ❍ Irregular ❑ Murmur
❑ Pacemaker: Date _____
Type _____

Respirations:_____ ❍ Regular ❍ Irregular
❑ Apnea periods ____sec.

Breath Sounds: ❑ Clear ❑ Crackles/Rales ❑ Wheezes/Rhonchi
❍ Diminished ❍ Absent
❑ Anterior: ❑ Right ❑ Left ❑ Posterior: ❑ Right ❑ Left
❑ Upper ❑ Lower ❑ Upper ❑ Lower
❑ Accessory muscles used ❑ O_2 @_____ LPM per _____
O_2 saturation _____%
❑ Other:_____
Does this patient have a trach? ❍ Yes ❍ No
Who manages? ❑ Self ❑ RN ❑ Caregiver/family

❑ **Cough:** ❍ Dry ❍ Acute ❍ Chronic
❑ Productive: ❍ Thick ❍ Thin
Color _____
Amount _____
❑ Unable to cough up secretions
❑ Dyspnea: ❑ Rest ❑ Exertion ❑ Ambulation _____feet
❑ During ADL's
❑ Orthopnea ❑ Other:_____

❑ **Chest Pain:** ❑ Anginal ❑ Postural ❑ Localized ❑ Substernal
❑ Radiating ❑ Dull ❑ Ache ❑ Sharp ❑ Vise-like
Associated with: ❑ Shortness of breath ❑ Activity ❑ Sweats
Frequency/duration:_____
_____
❑ Palpitations ❑ Fatigue

❑ **Edema:** ❑ Pedal Right/Left ❑ Sacral ❑ Dependent:_____
❑ Pitting: Left ❍ +1 ❍ + 2 ❍ +3 ❍ +4 ❑ Non-pitting
Right ❍ +1 ❍ + 2 ❍ +3 ❍ +4
Site:_____
❑ Cramps ❑ Claudication
❑ Capillary refill: ❍ Less than 3 sec ❍ Greater than 3 sec
❑ Other:_____

❑ **NO PROBLEM**

NUTRITIONAL STATUS

❑ NAS ❑ NPO ❑ No Concentrated Sweets
❑ Other:_____

Nutritional requirements (diet) (Locator #16)
_____
❍ Increase fluids _____ amt. ❍ Restrict fluids _____ amt.

Appetite: ❍ Good ❍ Fair ❍ Poor ❍ Anorexic

Eating patterns_____

❑ Nausea ❑ Vomiting:
Frequency_____ Amount_____

❑ Heartburn (food intolerance)

❑ Weight change: ❍ Gain ❍ Loss _____lbs.
x _____ ❍ week ❍ month ❍ year

❑ Other (specify, including history)_____

Directions: Check each area with "yes" to assessment, then total score to determine additional risk.	**YES**
Has an illness or condition that changed the kind and/or amount of food eaten.	❑ 2
Eats fewer than 2 meals per day.	❑ 3
Eats few fruits, vegetables or milk products.	❑ 2
Has 3 or more drinks of beer, liquor or wine almost every day.	❑ 2
Has tooth or mouth problems that make it hard to eat.	❑ 2
Does not always have enough money to buy the food needed.	❑ 4
Eats alone most of the time.	❑ 1
Takes 3 or more different prescribed or over-the-counter drugs a day.	❑ 1
Without wanting to, has lost or gained 10 pounds in the last 6 months.	❑ 2
Not always physically able to shop, cook and/or feed self.	❑ 2
TOTAL	

INTERPRETATION

0-2 Good. As appropriate reassess and/or provide information based on situation.

3-5 Moderate risk. Educate, refer, monitor and reevaluate based on patient situation and organization policy.

6 or greater High risk. Coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care.

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❑ **NO PROBLEM**

Patient Name_____ ID #_____

ELIMINATION

Urinary Elimination: (Check all applicable items)
❑ Urgency ❑ Frequency ❑ Burning ❑ Pain ❑ Hesitancy ❑ Nocturia
❑ Hematuria ❑ Oliguria ❑ Anuria
❑ Incontinence (details if applicable) _____
_____
❑ Diapers/other: _____
Color: ❍ Yellow/straw ❍ Amber ❍ Brown/gray ❍ Blood-tinged
❍ Other: _____
Clarity: ❑ Clear ❑ Cloudy ❑ Sediment ❑ Mucous ❑ Clots
Odor: ❍ Yes ❍ No
Urinary Catheter: Type (specify) _____
Date last changed _____
❑ Foley inserted (date) _____ with _____ French
Inflated balloon with _____ml ❑ without difficulty
Irrigation solution: Type (specify) _____
Amount_____ml Frequency_____Returns_____
❑ Patient tolerated procedure well ❍ Yes ❍ No
❑ Other (specify) _____
❑ NO PROBLEM

Bowel Elimination: (Check all applicable items)
❑ Flatulence ❑ Constipation ❑ Impaction ❑ Diarrhea
❑ Rectal bleeding ❑ Hemorrhoids ❑ Last BM _____
❑ Frequency of stools _____
Bowel regime/program: _____
❑ Laxative/Enema use: ❍ Daily ❍ Weekly ❍ Monthly
❑ Other: _____
❑ Incontinence (details if applicable) _____
❑ Diapers/other: _____
❑ Ileostomy/colostomy site (describe skin around stoma): _____
_____
❑ Other: _____ site (describe skin around stoma):
_____
❑ NO PROBLEM

ABDOMEN

❑ Tenderness ❑ Pain ❑ Distention ❑ Hard ❑ Soft ❑ Ascites
❑ Abdominal girth _____ inches
❑ Other: _____
❑ NG ❑ Enteral tube (type/size) _____
❑ Bowel sounds: ❑ Active ❑ Absent ❑ Hypoactive
❑ Hyperactive x _____ quadrants
❑ Other: _____
❑ NO PROBLEM

GENITALIA

❑ Discharge/Drainage: (describe) _____
❑ Lesions ❑ Blisters ❑ Masses ❑ Cysts
❑ Inflammation ❑ Surgical alteration
❑ Prostate problem: ❑ BPH ❑ TURP Date_____
❑ Self-testicular exam Frequency_____
❑ Menopause ❑ Hysterectomy Date_____
Date last PAP_____ Results_____
❑ Breast self-exam. frequency_____ ❑ Discharge: ❑ R ❑ L
❑ Mastectomy: ❑ R ❑ L Date_____
❑ Other (specify) _____
❑ NO PROBLEM

NEURO / EMOTIONAL / BEHAVIOR STATUS

❑ Headache: Location_____ Frequency_____
❑ PERRLA ❑ Pupils unequal
❑ Aphasia: ❑ Receptive ❑ Expressive
❑ Motor change: ❑ Fine ❑ Gross Site _____
❑ Dominant side: ❍ R ❍ L
❑ Weakness: ❑ UE ❑ LE Location _____
❑ Tremors: ❑ Fine ❑ Gross ❑ Paralysis Site_____
❑ Stuporous ❑ Hallucinations: ❑ Visual ❑ Auditory
Hand grips: ❍ Equal ❍ Unequal (specify) _____
❍ Strong ❍ Weak (specify) _____
❑ Psychotropic drug use (specify) _____
Dose / Frequency _____
❑ Other (specify) _____
_____
_____
❑ NO PROBLEM

MENTAL STATUS

(Locator #19)
❑ 1- Oriented ❑ 5 - Disoriented ❑ 8 - Other_____
❑ 2- Comatose ❑ 6 - Lethargic _____
❑ 3- Forgetful ❑ 7 - Agitated _____
❑ 4- Depressed _____

PSYCHOLOGICAL

Primary language _____
❑ Language barrier ❑ Needs interpreter_____
❑ Learning barrier: ❑ Mental ❑ Psychosocial ❑ Physical ❑ Functional
Unable to: ❑ Read ❑ Write Educational level _____
❑ Angry ❑ Difficulty coping
❑ Withdrawn ❑ Discouraged
❑ Flat affect ❑ Disorganized
❑ Spiritual/Cultural implications that impact care.
Spiritual resource _____
_____
Phone No. _____
❑ Depressed: ❍ Recent ❍ Long term Treatment:_____
Due to: ❑ Lack of motivation ❑ Inability to recognize problems
❑ Unrealistic expectations ❑ Denial of problems
❑ Sleep: ❍ Adequate ❍ Inadequate ❑ Rest: ❍ Adequate ❍ Inadequate
Explain _____
❑ Inappropriate responses to caregivers/clinician
❑ Evidence of abuse: ❍ Potential ❍ Actual ❑ Verbal ❑ Emotional
❑ Physical ❑ Financial
❑ Substance abuse: ❑ Drugs ❑ Alcohol ❑ Tobacco
Describe objective/subjective findings _____
_____
_____
_____
❑ Other (specify) _____
_____
❑ NO PROBLEM

MUSCULOSKELETAL

❑ Fracture (location) _____
❑ Swollen, painful joints (specify) _____
❑ Contractures: Joint_____ Location_____
❑ Atrophy_____ ❑ Poor conditioning
❑ Decreased ROM_____ ❑ Paresthesia_____

Patient Name_____ ID #_____

MUSCULOSKELETAL (Cont'd.)

❑ Shuffling ❑ Wide-based gait ❑ Weakness _____
❑ Amputation: ❑ R: ❑ BK ❑ AK ❑ UE (specify) _____
❑ L: ❑ BK ❑ AK ❑ UE (specify) _____
❑ Hemiplegia ❑ Paraplegia ❑ Quadriplegia
❑ Other (specify) _____
_____

❑ **NO PROBLEM**

FUNCTIONAL LIMITATIONS

(Locator #18A)

❑ Dyspnea with minimal exertion
❑ Bowel/Bladder incontinence
❑ Contracture_____
❑ Amputation_____
❑ Paralysis
❑ Other (specify)_____
❑ Hearing deficit
❑ Speech deficit
❑ Endurance
❑ Ambulation
❑ Legally blind

_____ ❑ **NO LIMITATIONS**

ACTIVITIES PERMITTED

(Locator #18B)

❑ Complete bedrest
❑ Bedrest/BRP
❑ Up as tolerated
❑ Transfer bed/chair
❑ Other (specify)_____
❑ Partial weight bearing
❑ Exercises prescribed
❑ Independent in home

_____ ❑ **NO RESTRICTIONS**

ENTERAL FEEDINGS - ACCESS DEVICE

❑ **N/A** ❑ **No Problem**

❑ Nasogastric ❑ Gastrostomy ❑ Jejunostomy
❑ Other (specify)_____
❑ Pump: (type/specify)_____
❑ Bolus ❑ Continuous
Feedings: Type (amt./rate) _____
Flush Protocol: (amt./specify) _____
Performed by: ❑ Self ❑ RN ❑ Caregiver
❑ Other _____
Dressing/Site care: (specify) _____
_____
_____
Interventions/Instructions/Comments_____
_____
_____

INFUSION

❑ **N/A**

❍ **Peripheral line** ❍ **Medline catheter** ❍ **Central line**

Type/brand _____
Size/gauge/length_____
❍ Groshong® ❍ Non-Groshong ❍ Tunneled ❍ Non-tunneled
Insertion site_____
Insertion date_____
Lumens: ❍ Single ❍ Double ❍ Triple
Flush solution/frequency_____
Patent: ❍ Yes ❍ No
Injection cap change frequency_____
Dressing change frequency_____
❍ Sterile ❍ Clean
Performed by: ❑ Self ❑ RN ❑ Caregiver ❑ Other _____
Site/skin condition _____
External catheter length_____

INFUSION (Cont'd.)

Other_____
_____

PICC Specific:
Circumference of arm_____
X-ray verification: ❍ Yes ❍ No

IVAD Port Specific:
Reservoir: ❍ Single ❍ Double
Huber gauge/length_____
Accessed: ❍ No ❍ Yes, date_____

Epidural/Intrathecal Access:
Site/skin condition_____
Infusion solution (type/volume/rate) _____
Dressing _____
Other_____
_____

❑ Medication(s) administered:
(name of drug)_____
Dose_____ Route_____
Frequency_____ Duration of therapy_____
❑ Medication(s) administered:
(name of drug)_____
Dose_____ Route_____
Frequency_____ Duration of therapy_____

❑ Pump: (type, specify)_____
Administered by: ❑ Self ❑ Caregiver ❑ RN ❑ Other_____
Purpose of Intravenous Access:
❑ Antibiotic therapy ❑ Pain control ❑ Lab draws
❑ Chemotherapy ❑ Maintain venous access
❑ Hydration ❑ Parenteral nutrition
❑ Other_____
❑ Infusion care provided during visit _____
_____
_____
Interventions/Instructions/Comments_____
_____
_____

APPLIANCES/AIDS/SPECIAL EQUIPMENT

❑ Brace ❑ Orthotics (specify)_____
❑ Transfer equipment: ❑ Board ❑ Lift
❑ Bedside commode
❑ Prosthesis: ❑ RUE ❑ RLE ❑ LUE ❑ LLE ❑ Other_____
_____
❑ Hospital bed: ❍ Semi-elec. ❍ Crank ❍ Spec. _____
Overlays_____
❑ Oxygen: HME Co._____
HME Rep._____ Phone_____
❑ Lifeline ❑ Fire Alarm ❑ Smoke Alarm
❑ Equipment needs (specify)_____
_____
❑ Other (specify) _____
_____
❑ Interventions/Instructions_____
_____
_____

Patient Name_____ ID #_____

FALL RISK ASSESSMENT

MAHC 10 - FALL RISK ASSESSMENT TOOL

REQUIRED CORE ELEMENTS **Assess one point for each core element "yes".** *Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.*	Points
Age 65+	❑ 1
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis.	❑ 1
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level.	❑ 1
Incontinence Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.	❑ 1
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	❑ 1
Impaired functional mobility May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	❑ 1
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	❑ 1
Poly Pharmacy (4 or more prescriptions – any type) All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	❑ 1
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	❑ 1
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patient's ability to adhere to the plan of care.	❑ 1
A score of 4 or more is considered at risk for falling **TOTAL**	

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LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

Safety Measures: (Locator #15)

- ❑ 1 - Bleeding precautions
- ❑ 2 - O_2 precautions
- ❑ 3 - Seizure precautions
- ❑ 4 - Fall precautions
- ❑ 5 - Aspiration precautions
- ❑ 6 - Siderails up
- ❑ 7 - Elevate head of bed
- ❑ 8 - 24 hr. supervision
- ❑ 9 - Clear pathways
- ❑ 10 - Lock w/c with transfers
- ❑ 11 - Infection control measures
- ❑ 12 - Walker/cane
- ❑ 13 - Other_____

LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE (Cont'd.)

HOME ENVIRONMENT SAFETY

Safety hazards in the home

Unsound structure	❍ Yes	❍ No
Inadequate heating/cooling/electricity	❍ Yes	❍ No
Inadequate sanitation/plumbing	❍ Yes	❍ No
Inadequate refrigeration	❍ Yes	❍ No
Unsafe gas/electrical appliances or outlets	❍ Yes	❍ No
Inadequate running water	❍ Yes	❍ No
Unsafe storage of supplies/equipment	❍ Yes	❍ No
No telephone available and/or unable to use phone	❍ Yes	❍ No
Insects/rodents	❍ Yes	❍ No
Medications stored safely	❍ Yes	❍ No
Emergency planning/fire safety:		
Smoke detectors on all levels of home	❍ Yes	❍ No
Tested and functioning	❍ Yes	❍ No
More than one exit	❍ Yes	❍ No
Plan for exit	❍ Yes	❍ No
Plan for power failure	❍ Yes	❍ No
Oxygen use:		
Signs posted	❍ Yes	❍ No
Handles smoking/flammables safely	❍ Yes	❍ No

Oxygen back-up: ❑ Available ❑ Knows how to use ❑ Electrical/fire safety

Comments:_____

Instructions/Materials Provided (Check all applicable items)

- ❑ Rights and responsibilities
- ❑ State hotline number
- ❑ Advance directives
- ❑ Do not resuscitate (DNR)
- ❑ HIPAA Notice of Privacy Practices
- ❑ OASIS Privacy Notice
- ❑ Emergency planning in the event service is disrupted
- ❑ Agency phone number/after hours number
- ❑ When to contact physician and/or agency
- ❑ Standard precautions/handwashing
- ❑ Basic home safety
- ❑ Disease (specify)_____
- ❑ Medication regime/administration
- ❑ Other_____

ADDITIONAL NOTES ON SKILLED CARE PROVIDED THIS VISIT

_____

_____

_____

_____

_____

_____

_____

ACTIVITIES OF DAILY LIVING (I-Independent; A-Assist; D-Dependent)

ACTIVITY	I	A	D	TEACH/TRAIN	ACTIVITY	I	A	D	TEACH/TRAIN
Eating	❍	❍	❍		Light housekeeping	❍	❍	❍	
Transfer	❍	❍	❍		Personal laundry	❍	❍	❍	
Dressing/Grooming	❍	❍	❍		Handling money	❍	❍	❍	
Bathing	❍	❍	❍		Using telephone	❍	❍	❍	
Toileting	❍	❍	❍		Reading	❍	❍	❍	
Ambulation	❍	❍	❍		Writing	❍	❍	❍	
Communication	❍	❍	❍		Managing Medications	❍	❍	❍	
Preparing light meals	❍	❍	❍		Other (Specify)	❍	❍	❍	
Preparing full meals	❍	❍	❍						

Patient Name_____ ID #_____

EMERGENCY PREPAREDNESS PLAN

Best refuge area in home (tornado):_____

Evacuation assist needed: ❍ Yes ❍ No Evacuation assistance provided by:_____

Alternate location:_____ Alternate contact:_____

SUMMARY CHECKLIST

MEDICATION STATUS: ❑ Medication regimen completed/reviewed (Locator #10) ❍ 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

BILLABLE SUPPLIES RECORDED? ❍ Yes ❍ No

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

DME SUPPLIES

(Locator #14)

WOUND CARE:
❑ 2x2's
❑ 4x4's
❑ ABD's
❑ Cotton tipped applicators
❑ Wound cleanser
❑ Wound gel
❑ Drain sponges
❑ Gloves:
❑ Sterile ❑ Non-sterile
❑ Hydrocolloids
❑ Kerlix size_____
❑ Nu-gauze
❑ Saline
❑ Tape
❑ Transparent dressings
❑ Other_____

IV SUPPLIES:
❑ IV start kit
❑ IV pole
❑ IV tubing
❑ Alcohol swabs
❑ Angiocatheter size _____
❑ Tape
❑ Extension tubings
❑ Injection caps
❑ Central line dressing
❑ Infusion pump
❑ Batteries size_____
❑ Syringes size _____
❑ Other_____

URINARY/OSTOMY:
❑ Underpads
❑ External catheters
❑ Urinary bag/pouch
❑ Ostomy pouch (brand, size)
❑ Ostomy wafer (brand, size)
❑ Stoma adhesive tape
❑ Skin protectant
❑ Other_____

FOLEY SUPPLIES:
❑ _____Fr catheter kit (tray, bag, foley)
❑ Straight catheter
❑ Irrigation tray
❑ Saline
❑ Acetic acid
❑ Other_____

DIABETIC:
❑ Chemstrips
❑ Syringes
❑ Other_____

MISCELLANEOUS:
❑ Enema supplies
❑ Feeding tube:
type_____ size_____
❑ Suture removal kit
❑ Staple removal kit
❑ Steri strips
❑ Other_____

SUPPLIES/EQUIPMENT:
❑ Bath bench
❑ Cane
❑ Commode
❑ Special mattress overlay
❑ Pressure relieving device
❑ Eggcrate
❑ Hospital bed
❑ Hoyer lift
❑ Enteral feeding pump
❑ Nebulizer
❑ Oxygen concentrator
❑ Suction machine
❑ Ventilator
❑ Walker
❑ Wheelchair
❑ Tens unit
❑ Other_____

PROFESSIONAL SERVICES

Locator #21

Complete this section if 485/POC is required

Emergency Code:_____

Check and specify patient specific orders for POC

❑ **DNR** - Do Not Resuscitate **(must have MD order)**

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 _____ Weeks
❑ Administer medication(s) (name, dose, route, frequency)_____
❑ 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/Precautions
❑ Teach Trach Care
❑ Administer Trach Care
❑ Other_____

INTEGUMENTARY
❑ Wound Care (specify each site) _____
❑ Evaluate Wound/Decub for Healings
❑ Measure Wound(s) Weekly
❑ Teach Wound Care/Dressing
❑ Other_____

ELIMINATION
❑ Foley _____ French inflated balloon with _____ml changed every _____
❑ Suprapubic Cath Insertion every_____
❑ Teach Care of Indwelling Catheter
❑ Teach Self - Cath
❑ Teach Ostomy Care
❑ Teach Bowel Regime
❑ Other_____

Patient Name_____ ID #_____

PROFESSIONAL SERVICES (Cont'd.)

Locator #21

Complete this section if 485/POC is required

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

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

MATERNAL/CHILD
- ❑ Evaluate Fetal/Maternal Status
- ❑ Evaluate Growth and Development
- ❑ Evaluate Parenting
- ❑ Teach S/S of Preterm Labor
- ❑ Teach Growth and Development
- ❑ Teach Apnea Monitor Use
- ❑ Other_____

LABORATORY
- ❑ Venipuncture for_____
- ❑ 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_____

ST - 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) _____

OTHER SERVICES (specify)_____
FREQUENCY/DURATION _____
- ❑ Homemaking
- ❑ Other_____

MSW - FREQUENCY/DURATION _____
- ❑ Evaluate and Treat
- ❑ Evaluate Family Situation
- ❑ Evaluate/Refer to Community Resources
- ❑ Evaluate Financial Status
- ❑ Other_____

REHABILITATION POTENTIAL / GOALS

Locator #22

Check goal(s), check for specifics and insert information.

DISCIPLINE GOALS AND DATE WILL BE ACHIEVED

Nursing:
- ❑ Demonstrates compliance with medication by _____ (date)
- ❑ Stabilization of cardiovascular pulmonary condition by _____ (date)
- ❑ Demonstrates competence in following medical regime by _____ (date)
- ❑ Verbalizes pain controlled at acceptable level by _____ (date)
- ❑ Demonstrates independence in _____ by _____ (date)
- ❑ Verbalizes/Demonstrates independence with care by _____ (date)
- ❑ Wound healing without complications by _____ (date)
- ❑ Expect daily SN visits to end by _____ (date)
- ❑ Other_____ by _____ (date)

Physical Therapy:
- ❑ Demonstrates ability to follow home exercise program by _____ (date)
- ❑ Other_____ by _____ (date)

Occupational Therapy:
- ❑ Demonstrates ability to follow home exercise program by _____ (date)
- ❑ Other_____ by _____ (date)

Speech Therapy:
- ❑ Demonstrate swallowing skills in ❑ formal ❑ informal dysphagia evaluation exercise program by _____ (date)
- ❑ Completes speech therapy program by _____ (date)
- ❑ Other_____ by _____ (date)

Aide:
- ❑ Assumes responsibility for personal care needs by _____ (date)
- ❑ Other_____ by _____ (date)

Medical Social Services:
- ❑ Verbalize information about community resources and how to obtain assistance by _____ (date)
- ❑ Other_____ by _____ (date)

DISCHARGE PLANS

- ❑ Return to an independent level of care (self-care)
- ❑ Able to remain in residence with assistance of primary caregiver/support from community agencies
- ❑ When patient knowledgeable about when to notify physician
- ❑ Able to understand medication regime and care related to diagnoses
- ❑ Medical condition stabilizes
- ❑ When maximum functional potential reached
- ❑ Other_____

D/C Summary sent to:_____ Date:_____

DISCUSSED WITH PATIENT: ❍ **Yes** ❍ **No** **REHAB POTENTIAL:** ❍ **Poor** ❍ **Fair** ❍ **Good** ❍ **Excellent**

SIGNATURE/DATES

X_____ _____
Patient/Caregiver (if applicable) *Date*

X_____ _____
Person Completing This Form (signature/title) *Date*