COMPREHENSIVE PEDIATRIC NURSING ASSESSMENT
WITH PLAN OF TREATMENT/485 INFORMATION

DATE OF SERVICE _____

TIME IN _____ **OUT** _____

Complete upper section according to organization guidelines

Medicaid Provider Number: (Locator #5) _____

Patient ID/Medical Record Number: (Locator #4)

_____

Start of Care Date: (Locator #2) _____ month/day/year

Certification Period: (Locator #3) (if applicable)

From _____ To _____

Patient's Name: (Locator #6)

_____ (First) ____ (MI)

_____ (Last) _____ (Suffix)

Patient Phone: _____ - _____ - _____

Patient Address: (Locator #6)

_____ (Street/Apt. No.)

_____ (City)

Patient State of Residence: (Locator #6) _____

Patient Zip Code: (Locator #6) _____

Email Address: _____

Birth Date: (Locator #8) _____ month/day/year

Medicaid/Waiver Number: ❑ NA-No Medicaid

(specify waiver) _____

PATIENT REPRESENTATIVE INFORMATION (see page 8)

Patient's HI Claim No.: (Locator #1)

❑ Same as Medicaid ❑ Private insurance

❑ CHIP (Childrens Health Insurance Program) ❑ Qualified health plan

❑ Self or family pays full or partial costs

❑ Other _____

Gender: (Locator #9) ❍ 1-Male ❍ 2-Female

Ethnicity and Race:

❍ American Indian or Alaska Native ❍ Native Hawaiian or Pacific Islander

❍ Asian

❍ Black or African-American ❍ White

❍ Hispanic or Latino ❍ Other

Primary Referring Physician/Pediatrician NPI: ❑ UK-Unknown or Not Available

_____

Phone: (Locator #24) _____ - _____ - _____

Name: (Locator #24) _____ (First) ____ (MI)

_____ (Last) _____ (Suffix)

Address: (Street/Apt. No.) (Locator #24)

_____

City: (Locator #24) _____

State: (Locator #24) Zip Code: (Locator #24)

_____ _____ _____

EMERGENCY PREPAREDNESS **PRIORITY CODE:**

Does the patient have an Advance Directives order? ❍ **No** ❍ **Yes**

❑ Address the patient's individualized emergency plan for emergency contact information. (Briggs form 3556)

PERTINENT BACKGROUND INFORMATION

PRIMARY REASON FOR HOME HEALTH: _____

_____

Primary Diagnosis/Reason for Home Care **ICD Code** (Locator #11)

a. _____ (_____) Date _____ ❍ O ❍ E

Other Diagnosis/Reasons **ICD Code** (Locator #13)

b. _____ (_____) Date _____ ❍ O ❍ E

c. _____ (_____) Date _____ ❍ O ❍ E

d. _____ (_____) Date _____ ❍ O ❍ E

e. _____ (_____) Date _____ ❍ O ❍ E

f. _____ (_____) Date _____ ❍ O ❍ E

History/Surgical Procedure **ICD Code** (Locator #12)

_____ (_____) Date _____ ❍ O ❍ E

_____ (_____) Date _____ ❍ O ❍ E

ALLERGIES: (Locator #17) ❑ None known

❑ Aspirin ❑ Penicillin ❑ Sulfa ❑ Pollen

❑ Eggs ❑ Milk products ❑ Insect bites

❑ Other _____

_____

IMMUNIZATIONS (check if current)

❑ DPT ❑ Measles ❑ Polio

❑ DT ❑ Mumps ❑ HBV

❑ MMR ❑ Rubella ❑ Hib

Is the patient from birth to 18 years current with the recommended CDC immunization schedule? ❑ Yes ❑ No ❑ Unknown

If no, (specify) _____

❑ Other (specify) _____

_____

PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES _____

_____

HOSPITALIZATIONS: ❑ No hospitalization within 90 days ❑ Yes Number of times _____

Hospitalization: ❑ 31-90 days ❑ 15-30 days ❑ 8-14 days ❑ In the last 7 days

Reason(s) _____

WELL CHILD CARE (if applicable) _____

_____ **Clinic last visit** _____ **Next visit** _____

PATIENT NAME – Last, First, Middle Initial	ID#

PERTINENT BACKGROUND INFORMATION (Cont'd.)

SCREENING/EARLY DETECTION

Did the newborn have a state specific Recommended Uniform Screening Panel (RUSP)? ❍ Yes ❍ No ❑ Unknown

Did the RUSP identify any significant organic conditions or disorders? ❍ Yes ❍ No ❑ Unknown

(specify)_____

TB skin test: ❍ No ❍ Yes, if yes,

date_____ results_____

Lead screening: ❍ No ❍ Yes, if yes,

date_____ results_____

Other (specify)_____

PROGNOSIS (Locator #20)

❍ 1-Poor ❍ 2-Guarded ❍ 3-Fair ❍ 4-Good ❍ 5-Excellent

NEWBORN/INFANT (Complete if applicable)

Newborn screen results_____

_____

Gestational age at birth _____ weeks

Birth weight less than 1500 g: ❍ Yes ❍ No

Birth wt. _____lb._____oz. Length _____in.

Head circumference_____ Chest circumference_____

Fontanels: ❑ Anterior ❑ Posterior

Umbilicus: ❑ Healed ❑ Hernia ❑ Inverted ❑ Everted

Maternal health problem during pregnancy: ❍ Yes ❍ No (if known, specify)_____

_____

NOTE: Additional newborn/infant related assessment criteria are identified by an asterisk (*) throughout the remainder of this form.

CHILDHOOD HISTORY

(H - History of; N - Negative; P - Present problem)

CONDITION	H	N	P	CONDITION	H	N	P
*Thrush	❑	❍	❍	Strep throat	❑	❍	❍
*Apnea	❑	❍	❍	Sinusitis	❑	❍	❍
Conjunctivitis	❑	❍	❍	Nosebleeds	❑	❍	❍
Croup	❑	❍	❍	Fracture(s)	❑	❍	❍
Pica	❑	❍	❍	Burn(s)	❑	❍	❍
Rubella	❑	❍	❍	Otitis media	❑	❍	❍
Rubeola	❑	❍	❍	Frequent ear infection	❑	❍	❍
Scarlet Fever	❑	❍	❍	Tonsillitis	❑	❍	❍
Mumps	❑	❍	❍	Frequent sore throat	❑	❍	❍
Chickenpox	❑	❍	❍	Bleeding problems	❑	❍	❍
Hepatitis	❑	❍	❍	Rheumatic fever	❑	❍	❍
Sickle Cell	❑	❍	❍	Headaches	❑	❍	❍
Lead poisoning	❑	❍	❍	Seizures–grand mal	❑	❍	❍
HIV	❑	❍	❍	Seizures–petit mal	❑	❍	❍
Pneumonia	❑	❍	❍	Other (specify)	❑	❍	❍
Asthma	❑	❍	❍		❑	❍	❍
Frequent colds	❑	❍	❍		❑	❍	❍

SKILLED OBSERVATION/ASSESSMENT

Check all applicable:

Mental Status: (Locator #19)

❑ Oriented ❑ Comatose ❑ Forgetful ❑ Depressed ❑ Hyperactive

❑ Disoriented ❑ Lethargic ❑ Agitated ❑ Other_____

SKILLED OBSERVATION/ASSESSMENT (Cont'd.)

Vitals: Temperature_____ ❍ F ❍ C ❑ Oral ❑ Axillary ❑ Tympanic ❑ Rectal

Pulse:_____ ❑ Radial ❑ Apical ❑ Brachial ❑ Carotid ❍ Regular ❍ Irregular

Heart Sounds: ❍ Regular ❍ Irregular

Blood Pressure: ❍ Arm ❍ Leg ❍ Lying ❍ Sitting ❍ Standing

Right_____ Left_____

Weight:_____ ❍ Actual ❍ Reported

Length/Height:_____ ❍ Actual ❍ Reported

Respirations_____ ❍ Regular ❍ Irregular

Breath Sounds: ❑ Clear ❑ Crackles ❑ Rales ❑ Rhonchi ❑ Wheeze

❑ Other_____

❑ Diminished ❑ Absent Location_____

O_2 saturation at _____%

HEAD/NECK

6 months and Under:

❑ Bulging Fontanel ❑ Depressed Fontanel ❑ Hydrocephaly

❑ Separated Sagittal Suture ❑ Microcephaly

6 months and Over:

❑ Head Asymmetry ❑ Head lag ❑ Enlarged Head

❑ Other_____

❑ Injuries/Wounds (specify)_____

❑ Masses ❑ Nodes: Site_____Size_____

❑ Other (specify, incl. history)_____

_____ ❑ **NO PROBLEM**

COGNITIVE STATUS/ABILITY

Uses language to communicate? ❍ Yes ❍ No

❑ Understood

❑ Usually understood (has trouble finding words but if given time little or no prompting needed)

❑ Often understood (Difficulty finding words and needs lots of prompting)

❑ Sometimes understood (has limited ability but is able to make understandable request such as food, drink, toilet)

❑ Rarely or never understood

❑ Communication device (specify)_____

❑ Not applicable (specify)_____

EYES/EARS

❑ Glasses ❑ Contacts: ❑ R ❑ L ❑ Prosthesis ❑ R ❑ L

❑ Jaundice ❑ Blurred vision ❑ Legally blind

❑ Sunset sign ❑ Tracks with eyes

❑ Drainage: ❑ R ❑ L (specify)_____

❑ Most recent eye exam (date)_____

❑ Infections_____

❑ Other (specify, incl. history)_____

_____ ❑ **NO PROBLEM**

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

❑ Ear device (cochlear implant) ❑ R ❑ L

❑ Vertigo ❑ Tinnitus

❑ Most recent hearing exam (date)_____

Infections: ❍ Yes ❍ No If yes, frequency_____

❑ P.E. tubes present: ❍ Yes ❍ No ❑ R ❑ L

❑ Other_____

_____ ❑ **NO PROBLEM**

PATIENT NAME – Last, First, Middle Initial | ID#

NOSE / THROAT / MOUTH

❑ Congestion ❑ Dysphagia ❑ Hoarseness ❑ Lesions
❑ Sore throat ❑ Masses ❑ Tumors ❑ Nasal flaring
❑ Drainage ❑ Nose bleeds ❑ Sucking swallowing deficit
❑ Palate intact Teeth present: ❍ Yes ❍ No
Oral hygiene practices_____
Dentist visits: frequency_____
❑ Other (specify, incl. history) _____
_____ ❑ **NO PROBLEM**

ENDOCRINE

❍ Hypothyroidism ❍ Hyperthyroidism
❑ Fatigue ❑ Intolerance to heat ❑ Intolerance to cold
❑ Diabetes: ❍ Type 1 ❍ Type 2 Date of onset_____
❑ Insulin dependent? ❍ Yes ❍ No
❑ Insulin dose / frequency (specify)_____
_____
On insulin since_____
❑ Diabetic diet ❑ Oral medication_____
❑ Hyperglycemia: ❑ Glycosuria ❑ Polyuria ❑ Polydipsia
❑ Hypoglycemia: ❑ Sweats ❑ Polyphagia ❑ Weak ❑ Faint ❑ Stupor
Blood Sugar:_____ ❍ Actual ❍ Reported
❑ Blood sugar ranges_____ ❑ Patient ❑ Caregiver Report
Monitored by: ❑ Self ❑ Caregiver ❑ Nurse
❑ Other_____
Frequency of monitoring _____
Competency with use of Glucometer _____
❑ Self-care/self observational tasks (specify) _____
❑ Abnormal growth pattern ❑ Abnormal sexual development
❑ Other (specify incl. history)_____
❑ **NO PROBLEM**

CARDIOPULMONARY

❑ Accessory muscles used ❑ Retractions
❑ O_2 @ _____ LPM per _____ O_2 saturation _____%
❑ Concentrator ❑ Liquid ❑ Other_____
Trach? ❍ No ❍ Yes, Brand_____ Size_____
Who manages? ❑ Self ❑ RN ❑ Caregiver ❑ Family
❍ Cuffed: _____mL's ❍ Cuffless ❍ Disposable ❍ Reusable
❍ Fenestrated ❍ Non-fenestrated inner cannula
❑ Speaking valve ❑ Humdivent ❑ Cap ❑ N/A
Comment_____
Ventilator? ❍ No ❍ Yes, ❍ Continous ❍ Intermittent
Vent type_____
Settings_____
Comment_____
❑ **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:**
Associated with: ❑ Shortness of breath ❑ Activity ❑ Sweats
Frequency/duration_____
❑ Palpitations ❑ Fatigue

CARDIOPULMONARY (Cont'd.)

❑ **Edema:**
Pedal Right: ❍ Non-pitting ❍ Pitting: ❍ +1 ❍ +2 ❍ +3 ❍ +4
Pedal Left: ❍ Non-pitting ❍ Pitting: ❍ +1 ❍ +2 ❍ +3 ❍ +4
Sacral: ❍ Non-pitting ❍ Pitting: ❍ +1 ❍ +2 ❍ +3 ❍ +4
Site_____
❑ Cyanosis (site) _____
❑ Capillary refill: ❍ Less than 3 seconds ❍ Greater than 3 seconds
❑ Skilled intervention (specify) _____
❑ Other _____
_____ ❑ **NO PROBLEM**

GASTROINTESTINAL

NUTRITIONAL REQUIREMENTS FOR AGE (diet) (Locator #16)
_____
For Newborn to 3 years:
Number of bottles of formula 24 hours _____
Name/Type of formula_____
Breast fed: ❍ Yes ❍ No
Combination Breast fed/bottle: ❍ Yes ❍ No
What percent of both: breast _____% bottle _____%
MEAL PATTERNS _____
_____
Appetite: ❍ Good ❍ Fair ❍ Poor ❑ NPO
Hydration adequate: ❍ Yes ❍ No
EATING BEHAVIORS _____
_____
❑ Eating disorder: ❑ Anorexia ❑ Bulimia
❑ Other (specify)_____
❑ Weight change: ❍ Gain ❍ Loss_____lb. x_____ ❍ wk. ❍ mo. ❍ yr.
❑ Increase fluids_____amt. ❑ Restrict fluids_____amt.
❑ Nausea ❑ Vomiting: Frequency_____ Amt._____
❑ Continent ❑ Incontinent ❑ Controlled with ostomy
❑ Occasionally incontinent – less than daily
❑ Frequently incontinent – daily but some control
LAST BM: _____ ❑ Frequency of stools_____
❑ Bowel sounds: active_____
absent_____
hypoactive_____
hyperactive _____

RU	LU
RL	LL

❑ Bowel regimen/program _____
_____
❑ Diarrhea (describe) _____
❑ Constipation: ❑ Chronic ❑ Acute ❑ Occasional
❑ Flatulence ❑ Abdominal distention
Girth _____ inches ❑ Firm ❑ Tender
❑ Laxative ❑ Enema use: ❑ Daily ❑ Weekly ❑ Monthly ❑ PRN
❑ Other_____
❑ Diapers/other _____
❑ Ileostomy ❑ Colostomy site (describe skin around stoma):
_____
_____
Ostomy care managed by: ❑ Self ❑ Caregiver ❑ Family
❑ Other _____
❑ **NO PROBLEM**

PATIENT NAME – Last, First, Middle Initial	ID#

ENTERAL FEEDINGS - ACCESS DEVICE

❑ **N/A**

❑ Nasogastric - Size_____ ❑ Gastrostomy - Size_____

❑ Jejunostomy - Size_____ ❑ PEG - Size_____

❑ Other (specify)_____

Pump: (type/specify) _____

Feedings: ❑ Bolus ❑ Continuous

Flush Protocol: (amt./specify) _____

_____

_____

Performed by: ❑ Self ❑ RN ❑ Caregiver ❑ Other_____

Dressing/Site care: (specify) _____

_____

_____

Interventions/Instructions/Comments_____

_____

_____

GENITOURINARY

❑ Continent - complete control, does not use any type of catheter or other urinary collection device

❑ Complete control with any catheter or ostomy

❑ Occasionally incontinent but less than daily

❑ Frequently incontinent - Daily

❑ Incontinent - No control present

❑ Diapers/day_____

Urine: Color_____ Amt._____ Odor_____

Frequency_____ ❑ Burning ❑ Itching

❑ Toilet trained: ❑ Day ❑ Night ❑ Both ❑ Bladder ❑ Bowel ❑ Both

❑ Enuresis; bedtime ritual _____

❑ Catheter type/brand: _____

❍ Foley ❍ Straight catheter ❍ External

❑ Other (specify, incl. pertinent history) _____

_____

_____

❑ **NO PROBLEM**

GENITALIA

❑ Circumcised ❑ Uncircumcised ❑ Precocious puberty

Scrotum: ❍ WNL ❍ Swollen

Testes: ❍ Descended ❍ Undescended: ❍ Right ❍ Left ❍ Bilateral

❑ Puberty ❑ Menarche, if checked, age_____ LMP_____

Pregnancy: Gravida_____ Para_____

❑ Estimated Date of Delivery_____

❑ Discharge (describe)_____

❑ Other (specify, incl. pertinent history)_____

_____

❑ **NO PROBLEM**

HEMATOLOGY

❑ Anemia ❑ Bilirubin, results _____

❑ Other (specify, incl. pertinent history)_____

_____

_____

❑ **NO PROBLEM**

NEUROLOGICAL

***REFLEXES:** Specify **N** - Normal, **A** - Abnormal, **NA** - Not Applicable

Rooting _____ Blinking _____ Moro's/Startle _____

Sucking _____ Palmar _____ Tonic neck _____

Orienting _____ Plantar _____ Knee jerk _____

Babinski's _____ Stepping/Dancing _____

Other (list with results)_____

_____

Cognitive development problems:

❑ Concepts ❑ Logic ❑ Impaired decision-making ability

❑ Memory loss: ❑ Short term ❑ Long term

❑ Stuporous ❑ Hallucinations: ❑ Visual ❑ Auditory

❑ Headache: Location_____ Freq._____

***INFANT MOTOR SKILLS:** ❑ Lifts head ❑ Crawls ❑ Creeps

Rolls over: ❑ Stomach to back ❑ Back to stomach

Sits: ❑ With assistance ❑ Without assistance

Stands: ❑ With assistance ❑ Without assistance

MOTOR SKILLS: ❑ Walks ❑ Runs ❑ Jumps ❑ Hops ❑ Skips ❑ Balance

❑ Motor change: ❑ Fine ❑ Gross

❑ Tremors: ❑ Fine ❑ Gross ❑ Paralysis

❑ Dominant side: ❍ R ❍ L

❑ Weakness: ❑ UE ❑ LE Location_____

HAND GRIPS: ❍ Equal ❍ Unequal, specify_____

❍ Strong ❍ Weak, specify_____

❑ Sensory loss, specify_____

❑ Numbness, specify_____

❑ Pupils: ❑ PERRLA ❑ Unequal ❑ Reactive

❑ Psychotropic drug use (specify) _____

_____

❑ Other (specify, incl. history)_____

_____

_____

❑ **NO PROBLEM**

PSYCHOSOCIAL

❑ Angry ❑ Flat affect ❑ Discouraged

❑ Withdrawn ❑ Difficulty coping ❑ Disorganized

❑ Recent family change: ❑ Birth ❑ Death ❑ Moved

❑ Divorce ❑ Other (specify)_____

❑ Suicidal: ❑ Ideation ❑ Verbalized

❑ Depressed: ❍ Recent ❍ Long term

Due to (if known)_____

❑ Substance use: ❑ Drugs ❑ Alcohol ❑ Tobacco

❑ Evidence of abuse: ❍ Potential ❍ Actual ❑ Verbal ❑ Emotional ❑ Physical ❑ Financial

Describe objective/subjective findings_____

_____

DESCRIBE RELATIONSHIPS WITH THE FOLLOWING:

Parents, Siblings, Peers_____

_____

USUAL SLEEP/REST PATTERN _____

SLEEPING ARRANGEMENTS _____

❑ Other (specify, incl. pertinent history)_____

_____

❑ **NO PROBLEM**

PATIENT NAME – Last, First, Middle Initial	ID#

SKIN CONDITIONS/WOUNDS

Skin: (Temperature, Color, Turgor) _____

_____ ❑ WNL

Check all that apply:

❑ Mongolian spots ❑ Itch ❑ Rash ❑ Dry ❑ Scaling
❑ Incision ❑ Wounds ❑ Lesions ❑ Sutures ❑ Staples
❑ Abrasions ❑ Lacerations ❑ Bruises ❑ Ecchymosis
❑ Edema ❑ Hemangiomas

Pallor: ❑ Jaundice ❑ Redness Turgor: ❍ Good ❍ Poor

❑ Other (specify, incl. pertinent history) _____

_____

_____

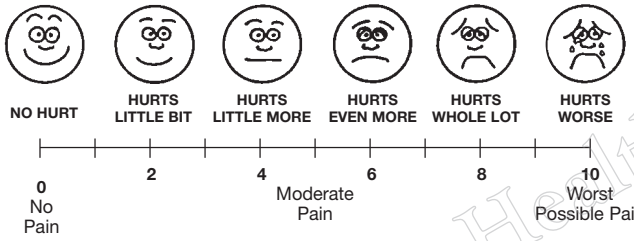
Description: _____

❑ **NO PROBLEM**

PAIN

Intensity: (using scales below)

Wong-Baker FACES Pain Rating Scale



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

List other pain assessment(s) used and score: _____

_____

❑ **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 _____

_____

_____

_____

_____

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.)			

PAIN (Cont'd.)

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

❑ Other _____

_____

Implications Care Plan: ❍ Yes ❍ No

MUSCULOSKELETAL

POSTURE _____

STRENGTH _____

ENDURANCE _____

❑ Scoliosis (type) _____

❑ Fracture (location) _____

❑ Decreased ROM (specify) _____

Dominant side: ❍ R ❍ L

❑ Rolls over ❑ Sits up

❑ Ambulatory ❍ Yes ❍ No

❑ Motor changes: ❑ Fine ❑ Gross (specify) _____

_____

_____

❑ Atrophy (describe) _____

_____

❑ Amputation ❑ BK ❑ AK ❑ UE ❑ R ❑ L

(specify) _____

How does the patient's condition effect their functional ability and safety

(explain) _____

_____

❑ Other (specify, incl. pertinent history) _____

_____

_____

_____

_____

_____

❑ **NO PROBLEM**

EDUCATIONAL STATUS

❑ Not enrolled in school
❑ Preschool
❑ Home Schooled
❑ Special education class(es)
❑ Educational level _____

❑ Regular class (no extra support)
❑ Regular class with special accommodations or assistance

PATIENT NAME – Last, First, Middle Initial | ID#

CHILD CARE ARRANGEMENTS

❑ Daycare ❑ Private sitter ❑ Family member

❑ Other_____

_____

BEHAVIOR AT DAY CARE/SCHOOL

❑ Disruptive behavior or inappropriate socially (e.g., screams, smears feces, causes disruptions with acting out)

❑ Causes property destruction (e.g., vandalizes, turns over furniture)

❑ Anger outbursts (e.g., has intense anger in reaction to certain circumstances)

❑ Demonstrates physical abuse to others (e.g., hitting, shoving biting)

❑ Exhibits verbal abuse to others (e.g., threatens others, swears)

Is a referral needed for a Mental Health Assessment? ❍ Yes ❍ No

(specify)_____

_____

_____

APPLIANCES/AIDS/SPECIAL EQUIPMENT

❑ Crutch(es) ❑ Wheelchair ❑ Cane ❑ Walker

❑ Brace ❑ Orthotics (specify) _____

❑ Transfer equipment: ❑ Board ❑ Lift

❑ Bedside commode

❑ Prosthesis: ❑ RUE ❑ RLE ❑ LUE ❑ LLE

❑ Other_____

❑ Grab bars: ❑ Bathroom ❑ Other _____

❑ Hospital bed: ❑ Semi-elec. ❑ Crank ❑ Spec._____

Overlays _____

❑ Oxygen: HME Co. _____

HME Rep._____ Phone_____

❑ Equipment needs (specify)_____

❑ Other (specify, incl. pertinent history) _____

_____

_____

_____

❑ **NONE USED**

ACTIVITIES PERMITTED

(Locator #18B)

❑ 1-Complete bedrest
❑ 2-Bedrest/BRP
❑ 3-Up as tolerated
❑ 4-Transfer bed/chair
❑ 5-Exercises prescribed
❑ 6-Partial weight bearing
❑ 7-Independent in home
❑ 8-Crutches
❑ 9-Cane
❑ A-Wheelchair
❑ B-Walker
❑ C-No restrictions
❑ D-Other (specify) _____
_____

FUNCTIONAL LIMITATIONS

(Locator #18A)

❑ 1-Amputation
❑ 2-Bowel/Bladder (Incontinence)
❑ 3-Contracture
❑ 4-Hearing
❑ 5-Paralysis
❑ 6-Endurance
❑ 7-Ambulation
❑ 8-Speech
❑ 9-Legally blind
❑ A-Dyspnea with minimal exertion
❑ B-Other (specify)_____
_____
_____

INFUSION

❑ **N/A**

❑ Peripheral: (specify)_____

❑ PICC: (specify, size, brand) _____

_____

External catheter length _____ ❍ inches ❍ cm

Arm circumference _____ ❍ inches ❍ cm

❑ Central ❑ Midline ❑ Midclavicular

Date of placement _____

❑ Intrathecal: ❑ Port ❑ Reservoir

❑ Epidural catheter: ❑ Tunneled ❑ Port

Date of placement _____

❑ Pump: (type, specify)_____

Administered by: ❑ Self ❑ Caregiver ❑ RN

❑ Other_____

Purpose of Intravenous Access:

❑ Antibiotic therapy ❑ Pain control ❑ Chemotherapy
❑ Maintain venous access ❑ Hydration ❑ Parenteral nutrition
❑ Other_____

_____

Interventions/Instructions/Comments _____

_____

_____

_____

LIVING ARRANGEMENTS/CAREGIVER

❑ House ❑ Apartment ❑ New environment

Patient lives alone? ❍ Yes ❍ No

ACTIVITIES: I - Independent, **PA** - Partial Assist, **D** - Totally Dependent			
Groom (brush hair, wash hands/face, brush teeth)	❍ I	❍ PA	❍ D
Bathing (shower or tub)	❍ I	❍ PA	❍ D
Shampoo hair	❍ I	❍ PA	❍ D
Dress upper body	❍ I	❍ PA	❍ D
Dress lower body	❍ I	❍ PA	❍ D
Toileting hygiene	❍ I	❍ PA	❍ D

Caregiver Primary language _____

❑ Language barrier ❑ Needs interpreter

❑ Interpreter used for: ❑ Child ❑ Youth ❍ Yes ❍ No

❑ Interpreter used either: ❑ Parent or ❑ Primary CG ❍ Yes ❍ No

❑ Learning barrier: ❑ Mental ❑ Psychosocial ❑ Physical ❑ Functional

❑ Able to: ❑ Read ❑ Write Educational level_____

❑ Spiritual ❑ Cultural implications that impact care

Spiritual resource_____ Phone No._____

Patient lives with:

Name _____

Relationship_____

Language spoken _____

Environment safe for patient? ❍ Yes ❍ No

Identified problems or High Risk in patient environment:

_____

_____

_____

PATIENT NAME – Last, First, Middle Initial	ID#

LIVING ARRANGEMENTS/CAREGIVER (Cont'd.)

Complete if patient's address is different:

Primary caregiver's name_____

Relationship_____

Address_____

Phone number_____

Secondary caregiver's name_____

Relationship_____

Address_____

Phone number_____

❑ No siblings

Name of siblings:

_____ Living in home? ❍ Yes ❍ No

_____ Living in home? ❍ Yes ❍ No

_____ Living in home? ❍ Yes ❍ No

_____ Living in home? ❍ Yes ❍ No

_____ Living in home? ❍ Yes ❍ No

_____ Living in home? ❍ Yes ❍ No

_____ Living in home? ❍ Yes ❍ No

ADVANCE DIRECTIVES

❑ Do not resuscitate ❑ Copies on file

❑ Organ donor ❑ Funeral arrangements made

❑ Education needed ❑ POA: ❑ Healthcare ❑ Financial

❑ State specific form(s)_____

Comments_____

_____

SERVICES CURRENTLY PROVIDED

Services currently provided to Patient/Service and/or Equipment needed:

❑ Home Health Aide Agency phone number_____

❑ Occupational Therapy Agency phone number_____

❑ Physical Therapy Agency phone number_____

❑ Speech-Language Pathology and Audiology services

Agency phone number_____

❑ Behavioral Intervention Program

Agency phone number_____

❑ Skilled Nursing Visit (provided on an intermittent basis)

Agency phone number_____

❑ Private Duty Nursing Agency phone number_____

❑ DME Phone number_____

❑ Assistive Technology Provider (specify)_____

Phone number_____

❑ Services ❑ Equipment needed

(specify)_____

Needs assistance with (check appropriate box(es):

❑ Meal preparation ❑ Assistance grooming

❑ Assistance feeding ❑ Assistance dressing

❑ Assistance bathing ❑ Mobility

❑ Transfer

❑ Transportation

❑ Other_____

_____

SAFETY

Safety Measures: (age specific) (Locator #15)

❑ 1. Fire/electrical safety

❑ 2. Burn prevention

❑ 3. Poisoning prevention

❑ 4. Falls prevention

❑ 5. Water safety

❑ 6. Siderails up

❑ 7. Clear pathways

❑ 8. Suffocation precautions

❑ 9. Aspiration precautions

❑ 10. Elevate head of bed

❑ 11. Seizure precautions

❑ 12. Transfer/ambulation safety

❑ 13. Wheelchair precautions

❑ 14. Proper use of assistive devices

❑ 15. Sharps and/or supplies disposals

❑ 16. Universal precautions

❑ 17. Cardiac prevention

❑ 18. Diabetic precautions

❑ 19. Oxygen safety/precautions

❑ 20. Bleeding precautions

❑ 21. Other_____

_____

HOME ENVIRONMENT SAFETY

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

❑ Written 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

❑ Diet_____

❑ Well child care_____

_____

❑ Activities_____

❑ Treatments_____

_____

❑ Injury prevention_____

❑ Growth and development_____

_____

❑ Other_____

_____

_____

_____

PATIENT NAME – Last, First, Middle Initial	ID#

CARE PREFERENCES/PATIENT'S PERSONAL GOALS

Did the ❑ Patient ❑ Representative ❑ Other:_____ communicate care preferences that involve the home health provided services?

For example, preferred visit times or days, etc. ❍ No ❍ Yes

If yes, list preferences:_____

Did the ❑ Patient ❑ Representative ❑ Other:_____ communicate any specific personal goal(s) the patient would like to achieve from this home health admission? For example, in the future they would like to play a special game, go to the movies or play music and dance, etc. ❍ No ❍ Yes

If yes, the ❑ Patient ❑ Representative ❑ Other:_____ discussed/communicated about the goal(s) with the assessing clinician and: (check all that apply)

- ❑ Agreed their personal goal(s) was realistic based on the patient's health status.
- ❑ Agreed their personal goal(s) needed to be modified based on the patient's health status.
- ❑ Agreed to and identified actions/interventions the patient is willing to safely implement, so the patient will be able to meet their goal(s) by the anticipated discharge date.
- ❑ The ❑ Patient ❑ Representative ❑ Other:_____ helped write a measurable goal(s), understandable to all stakeholders.
- ❑ The ❑ Patient ❑ Representative ❑ Other:_____ was informed, appeared to understand and agreed the personal goal(s) would be added to the patient's individualized plan of care and submitted to the physician responsible for reviewing and signing the plan of care.
- ❑ Other:_____
- ❑ Other:_____

Resumption of Care: ❍ No change(s) ❍ Goal(s) changed

List all the patient's goal(s) and indicate if **E**-Existing, **N**-New, **M**-Modified existing or **D**-Discontinued

___ _____

Note: *The IMPACT Act requires HHAs to take into account patient goal(s) and preferences in discharge and transfer planning. This process starts upon admission/resumption of care.*

STRENGTHS/LIMITATIONS

Based upon the patient's comprehensive assessment (physical, psychosocial, cognitive and mental status):

List the patient's strengths that contribute to them meeting their goal(s), both personal and the HHA measurable goals. For example, involved family, interest in returning to prior activities, cheerful attitude, cooperative, etc.

List the patient's limitations that might challenge progress toward their goal(s), both personal and the HHA measurable goal. For example, limited nutritional or financial resources, unsafe environment, multiple animals sharing the living space, etc.

How might the patient's limitation(s) affect their safety and/or progress?

Note: *CMS is looking for potential issues that may complicate or interfere with the delivery of the HHA services and the patient's ability to participate in his or her own plan of care.*

PATIENT REPRESENTATIVE

Does the patient have a representative? ❍ No ❍ Yes

If yes, is the person: ❍ Court declared ❍ Patient selected

Name and Title of Representative:

Representative Mailing Address:

Phone Number(s): Work:_____

Home:_____

Cell:_____

Email:_____

PATIENT NAME – Last, First, Middle Initial	ID#

RISK FACTORS/HOSPITAL ADMISSION/EMERGENCY ROOM

Risk factors identified and followed up on by: ❑ Discussion ❑ Education ❑ Training

Literature given to: ❑ Patient ❑ Representative ❑ Caregiver ❑ Family Member ❑ Other:_____

List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit (M1034 and M1036).

_____

_____

_____

_____

_____

_____

❑ N/A

Note: *Following a patient's hospital discharge, HHA are required by CMS to include an assessment of the patient's level of risk for hospital ED visits and hospital admission. Interventions are required in the patient's plan of care. When assessing the patient, pay particular attention to patients with CHF, AMI, COPD, CABG, pneumonia, diabetes or hip and knee replacements. Consider these factors co-morbidities, multiple medications, low health literacy level, history of falls, low socioeconomic level, dyspnea, safety, confusion, chronic wounds, depression, lives alone, support system, etc.*

PATIENT/CAREGIVER/REPRESENTATIVE/FAMILY EDUCATION AND TRAINING

(Check all that apply)

❑ Patient ❑ Caregiver ❑ Representative ❑ Family knowledgeable and able to verbalize and/or demonstrate independence with:

Wound care: ❍ Yes ❍ No ❍ N/A

Diabetic ❑ Foot exam ❑ Care: ❍ Yes ❍ No ❍ N/A

Insulin administration: ❍ Yes ❍ No ❍ N/A

Glucometer use: ❍ Yes ❍ No ❍ N/A

Nutritional management: ❍ Yes ❍ No ❍ N/A

❑ Oral ❑ Injected ❑ Infused ❑ Inhaled medication(s) administration: ❍ Yes ❍ No ❍ N/A

Pain management: ❍ Yes ❍ No ❍ N/A

Oxygen use: ❍ Yes ❍ No ❍ N/A

Use of medical devices: ❍ Yes ❍ No ❍ N/A

Catheter care: ❍ Yes ❍ No ❍ N/A

Trach care: ❍ Yes ❍ No ❍ N/A

Ostomy care: ❍ Yes ❍ No ❍ N/A

Other care(s):_____

_____

_____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family needs further ❑ education ❑ training with:_____

_____

❑ Caregiver ❑ Representative ❑ Family present at time of visit: ❍ Yes ❍ No ❑ Patient ❑ Caregiver ❑ Representative ❑ Family educated this visit for (specify):_____

❑ Patient ❑ Caregiver ❑ Representative ❑ Family appears to understand all information given: ❍ Yes ❍ No

Educated ❑ Patient ❑ Caregiver ❑ Representative ❑ Family about an action plan for when disease symptoms exacerbate (e.g., when to call the homecare nurse vs. emergency services): ❍ Yes ❍ No

Comment(s):_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT NAME – Last, First, Middle Initial	ID#

SKILLED CARE PROVIDED THIS VISIT

PATIENT/CAREGIVER RESPONSE

SUMMARY OF GROWTH AND DEVELOPMENT FOR AGE

(Review reference pages 13 & 14 as appropriate)

SUMMARY CHECKLIST

MEDICATION STATUS: ❑ Medication regimen completed/reviewed

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 ❑ No change ❑ Order obtained

BILLABLE SUPPLIES RECORDED? ❍ Yes ❍ No

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

REFERRAL: ❑ PT ❑ OT ❑ ST ❑ MSW ❑ Aide **Orders obtained:** ❍ Yes ❍ No

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

URINARY/OSTOMY (cont'd):
- ❑ 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:
- ❑ Bathbench
- ❑ Cane
- ❑ Commode

SUPPLIES/EQUIPMENT (cont'd):
- ❑ 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

PATIENT NAME – Last, First, Middle Initial	ID#

PROFESSIONAL SERVICES

Locator #21

Complete this section only when 485/POC is completed

Emergency Code: _____

Check and specify patient specific orders for POC

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

SN - FREQ./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) _____

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 _____

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 - FREQ./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 - FREQ./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 - FREQ./DURATION _____

❑ Evaluation and Treatment
❑ Voice Disorder Treatment
❑ Speech Articulation Disorder Treatment
❑ Dysphagia Treatment
❑ Receptive Skills
❑ Expressive Skills
❑ Cognitive Skills
❑ Other _____

HOME HEALTH AIDE - FREQ./DURATION _____

❑ Personal Care for ADL Assistance
❑ Other (specific task for HHA) _____

OTHER SERVICES (specify) _____
FREQ./DURATION _____

❑ Homemaking
❑ Other _____

MSW - FREQ./DURATION _____

❑ Evaluate and Treat
❑ Evaluate Family Situation
❑ Evaluate/Refer to Community Resources
❑ Evaluate Financial Status
❑ Other _____

PATIENT NAME – Last, First, Middle Initial	ID#

REHABILITATION POTENTIAL / GOALS

Locator #22

Check goal(s) 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 ❑ Caregiver ❑ Family knowledgeable about when to notify physician

❑ Patient ❑ Caregiver ❑ Family able to understand medication regimen and care related to diagnoses

❑ Medical condition stabilizes

❑ When maximum functional potential reached

❑ Other_____

❑ Other_____

DISCUSSED WITH: ❑ PATIENT ❑ FAMILY ❑ DESIGNATED CAREGIVER: ❍ Yes ❍ No

REHAB POTENTIAL: ❍ Poor ❍ Fair ❍ Good ❍ Excellent

SIGNATURE/DATES

X_____ _____ _____ ❍ AM ❍ PM

Patient/Caregiver (if applicable) *Date* *Time*

_____ _____ _____ ❍ AM ❍ PM

Person Completing This Form (signature/title) *Date* *Time*

OASIS INFORMATION

Date Reviewed_____ **Date Entered & Locked**_____ **Date Transmitted**_____

PATIENT NAME – Last, First, Middle Initial	ID#

DEVELOPMENTAL STAGES ASSESSMENT GUIDE

To remove for patient education, fold on the perforation at the left and tear.

Stage(s)	Motor (Fine/Gross)	Social/Cognitive/Language
INFANCY **(birth to 1 year)** Needs parents or caregivers who are affectionate, consistent, predictable and help children trust and bond with family and friends.	**Birth to less than 2 mos.** • Sucks on closed fist • Rooting reflex (ends approx. 3½ mos.) • Moro reflex (ends approx. 6 wks.) • Walking/Stepping reflex (ends approx. 6 wks.)	• Responds to voices • Communicates mainly by crying • Quiets to holding and cuddling • Reacts to loud sounds or bright patterns/objects
	2 mos. • Holds head up when lying prone • May roll over • Holds objects momentarily • Voluntarily grasps objects • Sits supported, holds head steady (within 3 mos.)	• Smiles responsively • Focuses on objects • Follows people with eyes • Vocalizes (other than crying)
	4 mos. • Bears weight on legs while held in lap • Brings objects to mouth • Rolls from front to back • Reaches with arms	• Responds to others with more vocalizing, squeals & laugh • Cries when left alone and stops when familiar person returns • Recognizes mom in a group • Drops objects to watch others pick up and looks where it lands (5 mos.)
	6 mos. • Reaches for objects • Sits with support or alone • Transfers items from hand to hand • Rolls over front to back, back to front • Plays with hands and feet	• Separation anxiety begins • Plays peek-a-boo • Turns to familiar noises • Imitates speech sounds (ma-ma, da-da, etc.)
	9 mos. • Creeps; pulls to stand • Can drink from cup with assistance • Crawls well • Firmer grasp • Waves bye-bye	• Separation anxiety continues • Learns to see self as a separate person from another • Plays pat-a-cake • Learns the meanings of words
	12 mos. • Climbs up and down chairs/steps • Walks without assistance (varies) • Bends, stoops, squats • Points with index finger • Babinski reflex gone by 1 yr.	• Understands “no” • Uses simple words – 2-8 words • Looks at pictures, turns pages • Imitates behavior • Associates words with gestures • Helps dress self
TODDLER **(1-3 yrs. old)** Needs experiences in caring for themselves, (e.g. feeding themselves, toilet behaviors, dressing). Needs parents who give choices within limitations and boundaries.	**18 mos.** • Pulls or pushes toy while walking • Walks sideways and backwards • Drinks regularly from a cup • Builds small towers of blocks • Tries to climb out of bed • Runs, trots, climbs • Plays ball • Scribbles with big crayons	• Recognizes names of major body parts • Listens to stories, enjoys rhymes • Enjoys singing songs/playing games • Follows simple commands • Understands more words than can say
	2 yrs. old • Loves to be chased • Able to remove clothing • Toilet training started • Kicks a ball forward • Enjoys dancing • Turns pages one at a time • Recognizes shapes • Throws ball overhand • Starts showing hand preference • Enjoys playground activities	• Vocabulary of over 200 words • Has 2 way conversation • Learns everything has a name and constantly asks “what’s that?” • May be aware of cause/effect but not of dangers • Short attention span

PATIENT NAME – Last, First, Middle Initial | ID#

DEVELOPMENTAL STAGES ASSESSMENT GUIDE

To remove for patient education, fold on the perforation at the right and tear.

Stage(s)	Motor (Fine/Gross)	Social / Cognitive / Language
TODDLER (cont'd.) **(1-3 yrs. old)**	**3 yrs. old** • Washes/dries own hands • Learns to hold pencil in writing position • Pedals and steers tricycle well • Loves to draw with chalk and crayons • Kicks ball in intended direction • Able to do 2 activities at once	• Names at least four pictures in a book • Understands number concept (counting stairs) • Begins to use pronouns (I, me) • May begin asking "why"
PRESCHOOLER Needs parents who let children participate in family work activities. Needs teachers who give children projects that they can complete to gain a sense of achievement. Needs parents and teachers who correct children with logical consequences. Sibling rivalry is frequent.	**4-5 yrs. old** • Learns to dress self without help • Able to express self verbally and begins to write • Able to draw pictures well by 5 yrs. old • Hops on one foot • Balances on one leg • Alternates feet when climbing stairs	• Egocentric • Logic is intuitive • Words have a single meaning or aspect • By 5 yrs. old can count to 10 or more objects correctly • Knows first and last name • Knows four different colors
SCHOOL AGE Needs experiences in building, creating, and accomplishing to gain a feeling of adequacy. Needs encouragement and deserved praise to achieve competence. Needs academic, social, physical and work skills for healthy self esteem. Needs teachers and parents who are nurturing to help children discover and develop special talents and abilities.	**6-12 yrs. old** • Learns to read and write well • Ability to express self with art, improves • Participates in vigorous physical activity	• Early years more supervised play, older, more independent team oriented, physical activity • Deductive reasoning • Classifies by multiple dimensions • Imitates and completes tasks or school projects • Attends appropriate grade for age
ADOLESCENT Needs experience in developing ego, identity, including moral, social and vocational identity. Needs parents, teachers and others who appreciate the adolescent as a unique and worthwhile individual.	**13-18 yrs. old** • Early in stage, rapid physical growth (girls usually attain increasing strength and coordination before boys) • Motor skills reach adult level	• Shift to abstract thinking • Shift away from egocentrism • Deductive reasoning is well developed • Cognition is adult type • Attending appropriate grade for age • Starts/Makes plan for future (college, work, etc.)

PATIENT NAME – Last, First, Middle Initial | ID#