SG	Safety Goal
#	POC (CMS - 485) Box

RECERTIFICATION COMPREHENSIVE ADULT ASSESSMENT
WITH CMS 485 (POC) INFORMATION

❑ PT ID PERFORMED VIA NAME, DOB, FACE RECOGNITION AND ADDRESS BEFORE SERVICE PROVIDED (SG)

(M0030) Start of Care Date: __ __ / __ __ / __ __ __ __ (2)
month day year

Certification Period: (3)
From __/___/_______ To___/___/_______

TIME IN ________ TIME OUT ________
DATE ______/______/______

Provider Number: _ _ _ _ _ _ _ _ _ _ (5)

Agency Name:______________________________ (7)

Physician name: ______________________________

Phone:______________________

Address: ______________________________ (24)
____

Phone Number: ______________________________

Employee's Name/Title Completing the Assessment:
____

PHYSICIAN: Date last contacted: ___/___/_______ Date last visited: ___/___/_______ Reason: ______________________

Other Physician (if any): ______________________________
Address: ______________________________
____
Phone Number: ______________________________

Patient ID Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ (4)
(Medical Record)
(6) **Patient Name:**______________________________
Address: ______________________________
(6) ______________________________
Patient Phone: ______________________ ❑ ALF / AFHC (circle)
Social Security Number:________________Name: ______________
(1) Phone: ______________
Medicaid Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ (1)
Birth Date: __ __/ __ __ / __ __ __ __ **Gender:** ❑ **Male** ❑ **Female** (9)
(8) **month / day / year**

Any change from previous episode in Emergency Information: ❑ No ❑ Yes, update the following info:
Emergency/Disaster Plan Classification Code: ______ *Complete new Emergency/Disaster form*

EMERGENCY CONTACT: ______________________________
Address: ______________________________
Phone: ________________ Relationship: ______________
OTHER: ______________________________
Evacuation Form needed? Emergency Registration Completed (please document)
____

CHIEF COMPLAINT: ______________________________
____
ANY MODIFY ORDERS OR STATUS CHANGES FROM PREVIOUS EPISODE:
____
____
PREVIOUS OUTCOMES:______________________________
What negative findings substantiate this Patient to be recertified?
____
____
____

Summary of the Services that need to be continued (State frequency, duration, amount):
❑ SN Comment:______________ ❑ MSW Comment:______________
❑ PT Comment:______________ ❑ Aide Comment:______________
❑ OT Comment:______________ ❑ Other: Comment:______________
❑ ST Comment:______________

RECENT HOSPITALIZATION? ❑ No ❑ Yes, dates _ _ _ _ - _ _ _ _
Reason: ______________________________
New diagnosis/condition? ❑ No ❑ Yes, specify ______________
IMMUNIZATIONS: ❑ Up-to-date ❑ H1N1
Needs: ❑ Influenza ❑ Pneumonia ❑ Tetanus ❑ Other (specify) ______________
____

VITAL SIGNS: **Blood Pressure:** ❑ Sitting/lying R ________ L ________
❑ Standing R ________ L ________ ❑ Rest ❑ Activity
Temperature:________
❑ Oral ❑ Axillary
❑ Rectal ❑ Tympanic
❑ Cheynes Stokes
Pulse: ❑ Apical______ ❑ Brachial
❑ Radial______ ❑ Carotid ______
❑ Regular ❑ Irregular
Respirations: ________
❑ Death rattle ❑ Apnea periods -sec.
❑ Regular ❑ Irregular ❑ Accessory muscles used

DIAGNOSIS: Primary & Other Diagnosis (12) ICD-9-CM (12)

Primary & Other Diagnosis	ICD-9-CM	Date
______________________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________________	(___ ___ ___ ___ ___)	Date ____/____/____

Surgical Procedure (12) ICD-9-CM (12)

Surgical Procedure	ICD-9-CM	Date
______________________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________________	(___ ___ ___ ___ ___)	Date ____/____/____

PATIENT NAME - Last, First, Middle Initial	Med. Record #

SAMPLE 305.818.5940

COMPREHENSIVE ADULT RECERT ASSESSMENT
WITH CMS 485 (POC) INFORMATION

PROGNOSIS: 20

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

SYSTEM REVIEW

VISION

❑ Glasses ❑ Glaucoma ❑ Jaundice
❑ Contacts: R / L ❑ Blurred vision ❑ Ptosis
❑ Prosthesis: R / L ❑ Legally blind
❑ Infections____
❑ Cataract surgery: **Site**________ **Date** ___/___/___
❑ Other (specify, incl. hx) ________
❑ **NO PROBLEM**

EARS

❑ HOH: R / L ❑ Deaf: R / L ❑ Hearing aid: R/L
❑ Vertigo ❑ Tinnitus
❑ Other (specify, incl. hx)________
❑ **NO PROBLEM**

HEAD/NECK

❑ Headache(❑ see Neurological section)
❑ Injuries/Wounds (❑ see Skin Condition/Wound section)
❑ Masses/Nodes: **Site**________ **Size**________
❑ Alopecia ________
❑ Other (specify, incl. hx)________
❑ **NO PROBLEM**

NOSE/THROAT/MOUTH

NOSE

❑ Congestion ❑ Epistaxis
❑ Loss of smell ❑ Sinus prob.
❑ Nose surgery: ________
❑ Other (specify, incl. hx)
❑ **NO PROBLEM**

THROAT

❑ Dysphagia ❑ Hoarseness
❑ Lesions ❑ Sore throat
❑ Other (specify, incl. hx)
❑ **NO PROBLEM**

MOUTH

❑ Dentures: Upper /Lower /Partial ❑ Masses/Tumors
❑ Gingivitis ❑ Ulcerations ❑ Toothache
❑ Any mouth surgery/procedure: ________
❑ Other (specify, incl. hx)________ ❑ **NO PROBLEM**

ENDOCRINE

❑ Enlarged thyroid ❑ Fatigue ❑ Intolerance to heat/cold
❑ Diabetes: Type I/Type II Onset ___/___/___
❑ Diet/Oral control X ________ ❑ mos. ❑ years
❑ Med./dose/freq. ________
❑ Insulin/dose/freq. ________
❑ Hyperglycemia: Glycosuria / Polyuria / Polydipsia
❑ Hypoglycemia: Sweats/Polyphagia/Weak/Faint/Stupor
❑ Blood Sugar Range ________
❑ Self-care/Self-observational tasks (specify)________
❑ Other (specify, incl. hx) ________
❑ NO PROBLEM

CARDIOVASCULAR STATUS

❑ Chest pain: ❑ Anginal ❑ Postural ❑ Localized ❑ Substernal
❑ Radiating ❑ Vise-like ❑ Sharp ❑ Dull ❑ Ache
Associated with: ❑ SOB ❑ Activity ❑ Sweats
Frequency/duration________
Other (specify)________
❑ Palpitations: Nocturnal/Persistent/intermittent
Other (specify) ________
Heart rate: ❑ Regular ❑ Irregular ❑ Reg./Irreg.
❑ Orthostatic hypotension ❑ Syncope ❑ Vertigo
❑ BP↑ (specify) ________
Heart sounds: ❑ Reg. ❑ Irreg. (specify)________
❑ Pulse deficit (specify) ________
❑ Edema: ❑ Pedal R/L ❑ Dependent: ________
❑ Pitting +1/+2/+3/+4 ❑ Non-pitting (site)________
❑ Claudication: R calf/L calf/Night changes
❑ JVD ❑ Fatigue
❑ Thrombus: Site________ Rx________
❑ Cramps: LE/UE/Night (site)________
❑ Cyanosis (site) ________
❑ Cap refill: <3 sec./ >3 sec.
❑ Pulses: LDP/LPT/RDP/RPT
❑ Pacemaker: Date ___/___/___ Type________
❑ Other (specify incl. hx) ________
❑ **NO PROBLEM**

RESPIRATORY STATUS

Breath sounds: ❑ Clear ❑ Crackles ❑ Wheeze ❑ Absent
❑ Cough: Dry/Acute/Chronic
❑ Productive: Thick/Thin/Difficult Color________
❑ Smoker:________ packs/day X ________ years
❑ Dyspnea: ❑ Rest ❑ Exertion: amb. feet________
during ADLs________
❑ Orthopnea: # of pillows ________
❑ Crepitus/❑ Fremitus: Location ________
❑ Hemoptysis: Frequency________ Amt.________
❑ Barrel chest ❑ Skin temp/color change ❑ Percussion: Resonant/Tympanic/Dull
❑ Chart lobe: ❑ R ❑ L; ❑ Lat. ❑ Ant. ❑ Post.
❑ O_2 Sat. ________
❑ O_2 use: ________ L/min. by ❑ Mask ❑ Nasal ❑ Trach
❑ Gas ❑ Liquid ❑ Concentrator
❑ Oxygen Precaution/Fire Prevention followed/explained to patient SG
❑ Other (specify, incl. hx) ________
❑ NO PROBLEM

FUNCTIONAL LIMITATIONS 18A

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

❑ Generalized Weakness ❑ Productive cough ❑ Legs weak
❑ Arthralgia ❑ Heartburn ❑ Back Pain
❑ Dizziness ❑ Pain on ambulation ❑ Decreased Bil. breath sounds
❑ Headache ❑ Unsteady Gait ❑ Palpitations
❑ Insomnia ❑ Varicositis on lower ext. ❑ Limited Mobility
❑ Anxiety ❑ Edema in ________ ❑ Limited ROM
❑ SOB on exertion ❑ Chest pain on exertion ❑ Leg cramps
❑ Poor vision ❑ Fatigues at times ❑ Freq. Coughing episodes
❑ Needs assistance of 1 person

HOMEBOUND REASON: 18A

(Mark all that apply):
❑ Medical restrictions
❑ **Needs assist of 1-2 persons**
❑ Unsteady Gait
❑ Needs assistance for all activities (ADL's)
❑ Generalized Weakness ❑ Dependent upon adaptive device(s)
❑ Requires assistance to ambulate/Decreased Range of Motion
❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home without assistance
❑ Mobility/Ambulatory device(s) used: ________
❑ Severe SOB, SOB upon exertion, amb. ____ feet
❑ Bedbound (Partial/Complete)
❑ Other (specify): ________

GENITOURINARY STATUS

(Check all that apply:) ❑ Burning/pain ❑ Hesitancy ❑ Hematuria ❑ Oliguria/anuria ❑ Urgency/frequency ❑ Nocturia x ________
❑ **Incontinence:** ❑ Urinary ❑ Bowel ________ ❑ Diapers/other: ________
Color: ❑ Yellow/straw ❑ Amber ❑ Brown/gray ❑ Blood-tinged ❑ Other:________ **Clarity:** ❑ Clear ❑ Cloudy ❑ Sediment/mucous
Odor: ❑ Yes ❑ No ________ ❑ **Urinary Catheter:** Type ________ Last changed on: ________ Foley inserted (date)________ with________ French
Inflated balloon with ______mL ❑ without difficulty ❑ Suprapubic Irrigation solution: Type (specify):________ Amount _____mL Frequency_____ Returns______
Patient tolerated procedure well ❑ Yes ❑ No ❑ Urostomy (describe skin around stoma): ________

PATIENT/CLIENT NAME - Last, First, Middle Initial | Med. Record #

SAMPLE 305.818.5940

NUTRITIONAL STATUS

16 DIET, Nutritional requirements: ❑ Controlled Carbohydrate
❑ 2 gm Sodium ❑ Low Sodium ❑ NAS ❑ NPO ❑ 1800 cal ADA
❑ Low Fat ❑ Low cholesterol Other: ____________
❑ Increase fluids: ________ amt. ❑ Restrict fluids ________ amt.
Appetite: ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Anorexic
❑ Nausea ❑ Vomiting: Frequency: ____________
Amount: ____________
❑ **Heartburn** (food intolerance): Frequency: ____________
❑ Other: ____________

NUTRITION HEALTH SCREEN

Directions: Circle 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 > 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.

❑ **NO PROBLEM**

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ELIMINATION STATUS

Last BM ____/____/____ **Usual frequency** ____________
❑ Diarrhea: Black / watery / Sanguineous ❑ <3x/day ❑ >3x/day
Mucus/Pain/Foul odor/Frothy Amount ____________
❑ Abnormal stools: Gray/Tarry/Fresh blood
❑ Constipation: Chronic/Acute/Occasional
❑ Lax./Enema use: Type ____________ Freq. ________
❑ Hemorrhoids: Internal/External/Painful
❑ Rx (specify) ____________
❑ Flatulence: Freq. ____________
❑ Impaction ❑ Incontinence of stool: Freq. ____________
❑ Abdominal distention: Cramping/Pain Freq. ____________
❑ Ascites: Girth ________ inches
Firm/Tender X ________ quads
Bowel sounds: Active/Hyperactive X ________ quads
❑ Absent X ________ quads
Rebound/Hot/Red/Discolored
❑ Colostomy: Sigmoid/Transverse Date ____/____/____

❑ **NO PROBLEM**

PSYCHOSOCIAL

Primary language: ❑ English ❑ Spanish ❑ Creole ❑ Russian ________
❑ Language barrier ❑ Needs interpreter ____________
❑ Learning barrier: Mental/Psychosocial/Physical/Functional
❑ Able to read/write Educational level ____________
❑ Spiritual/Cultural implications that impact care.
Spiritual resource ____________ Phone No. ____________
❑ Angry ❑ Flat affect ❑ Discouraged ❑ Suicidal: Ideation /Verbalized
❑ Withdrawn ❑ Difficulty coping ❑ Disorganized
❑ Substance use: Drugs/Alcohol/Tobacco
Plan ____________

❑ Depressed: Recent/Long term Fix ____________
Due to: ❑ Lack of motivation ❑ Inability to recognize problems
❑ Unrealistic expectations ❑ Denial of problems ❑ Other, specify ________
❑ Inappropriate responses to caregivers/clinician ❑ Invested in "sick role"
❑ Inappropriate follow-through in past
❑ Evidence of abuse: ❑ Potential ❑ Actual ❑ Verbal/Emotional ❑ Financial ❑ Physical

MENTAL STATUS: 19
❑ 1 - Oriented ❑ 3 - Forgetful ❑ 5 - Disoriented ❑ 7 - Agitated
❑ 2 - Comatose ❑ 4 - Depressed ❑ 6 - Lethargic
❑ 8 - Other: ____________
❑ Forgetful at times ❑ Irritable ❑ Anxious ❑ Alert ❑ **NO PROBLEM**

ACTIVITIES PERMITTED

CMS 485 (POC): 18B

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

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) ____________

GENITALIA

❑ Discharge/Drainage: Urine/Vag. mucus/Feces ❑ Surgical alteration
❑ Lesions/Blisters/Masses/Cysts ❑ Inflammation
❑ Prostate problem: BPH/TURP Date ____/____/____
❑ Self-testicular exam Freq. ____________
❑ Menopause: ❑ Hysterectomy Date ____/____/____
Date last PAP ____/____/____ Results ____________
❑ Breast self-exam. freq. ____________ ❑ Discharge: R/L
❑ Mastectomy: R/L Date ____/____/____
❑ Other (specify incl. hx) ____________

❑ **NO PROBLEM**

HEMATOLOGY/ IMMUNE

❑ Anemia: Iron deficient/Pernicious ❑ 2o Bleed: GI/GU/GYN/Unknown
❑ Thrombocytopenia ❑ Coagulation disorders Ablastic/Hemolytic/Polycythemias
❑ Hemophilia, other ____________
❑ Malignancies (specify): ____________
Prior Rx ____________
Complications ____________
❑ Other (specify, immunological problem) ____________

❑ **NO PROBLEM**

NEUROLOGICAL

❑ Slurred speech ❑ Oriented X ________
❑ Syncope ❑ Insomnia/Change in sleep pattern
❑ Sensory loss ❑ Vertigo
❑ Numbness ❑ Ataxia
❑ Impaired decision-making ability ❑ Hx of frequent falls
❑ Memory loss: Short term/Long term
❑ Headache: Loc. ____________ Freq. ________
❑ Aphasia: Receptive/Expressive ❑ Motor change: Fine/Gross
❑ Weakness: UE/LE Location ____________
❑ Tremors: Fine/Gross/Paralysis
❑ Stuporous/Hallucinations: Visual/Auditory
❑ Unequal pupils: R/UPERRLA
Hand grips: Equal/Unequal, specify ____________
Strong/Weak, specify ____________
❑ Psychotropic drug use (specify) ____________
Dose/Freq. ____________
❑ Other (specify, incl. hx) ____________

❑ **NO PROBLEM**

PATIENT/CLIENT NAME - Last, First, Middle Initial	ID#

SAMPLE 305.818.5940

SAFETY MEASURES

Safety Measures: CMS485 (POC) 15

- ❑ Cast Precautions
- ❑ Change position slowly
- ❑ Coumadin/Heparin Precautions
- ❑ Do not lift, bend, stoop
- ❑ Good handwashing technique
- ❑ Oxygen Precaution/Fire prevention SG
- ❑ Practice Universal Precautions
- ❑ Respiratory Precautions
- ❑ Diabetic Precautions
- ❑ Wound/Decubitus precautions
- ❑ Adequate lighting
- ❑ Prevent Cardiac Overload
- ❑ Prevent Falls and Injuries SG
- ❑ Safe Ambulation
- ❑ Prev. Infection Complications
- ❑ Seizure Precautions
- ❑ Suicide precautions
- ❑ Support due functional limitation
- ❑ Teach coping skills
- ❑ Safe storage/disposal syringes
- ❑ G.I. Precautions
- ❑ G.U. Precautions
- ❑ Safe Transfers
- ❑ SAN Precautions
- ❑ Catheter Care
- ❑ Provide Emotional Support
- ❑ Emergency Plan
- ❑ Cardiac Precautions
- ❑ Maintain Safe/clear Environment
- ❑ Maintain Good Skin care
- ❑ Clear pathways
- ❑ Correct handwashing technique SG
- ❑ Check bathroom, floor/stairs for safety hazards
- ❑ Other: ____________
- ❑ Oxygen: HME Co. ____________

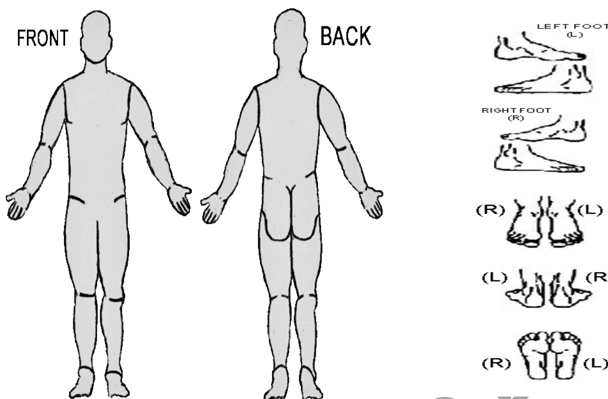
Phone: ____________

❑ Fire Alarm ❑ Smoke Alarm

SKIN CONDITION/WOUNDS/LESION

❑ Itch ❑Rash ❑Dry ❑ Scaling ❑Incision ❑Wounds ❑ Lesions
❑Decubitus ❑ Fistulas ❑Abrasions ❑Lacerations ❑ Sutures ❑Staples
❑ Bruises ❑ Ecchymosis Pallor: ❑Jaundice ❑Redness
Turgor: ❑Good ❑Poor Edema: ❑Lymph ❑Hema. ❑NO PROBLEM
Other (specify, incl. pertinent hx) ____________

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below.



CONDITION	#1	#2	#3	#4
Size (cm)				
Depth / Stage				
Drainage/Amt.				
Tunneling				
Odor / Sur. Tis.				
Edema / Stoma				

ALLERGIES

17

❑ None known / NKA ❑ Aspirin ❑ Eggs ❑ Insect bites
❑ Penicillin ❑ Sulfa ❑ Animal dander and urine ❑ Dairy/Milk products
❑ Iodine ❑ Pollens and mold spores ❑ Dust mites
❑ Other ____________

MUSCULOSKELETAL

❑ Fracture (location) ____________
❑ Swollen, painful joints (specify) ____________
❑ Contractures: Joint ____________ Location ____________
❑ Atrophy ❑ Poor conditioning
❑ Decreased ROM ____________ ❑ Paresthesia ____________
❑ Shuffling/Wide-based gait ❑ Weakness
❑ Amputation: BK/AK/UE; R/L (specify) ____________
❑ Hemiplegia ❑ Paraplegia ❑ Quadriplegia
❑ Other (specify, incl. pertinent hx) ____________

APPLIANCES/AIDS/SPECIAL EQUIPMENT: ❑ Cane ❑ Walker
❑Wheelchair ❑ Crutch(es) ❑ Lifts ❑ Bedside Commode ❑ Prosthesis: ____________
❑ Other (specify): ____________ ❑Hospital bed

PAIN MANAGEMENT

Location ____________ Origin: ____________
Onset ____________
Present Pain Management Regimen ____________
Effectiveness ____________
Other (specify) ____________
Quality (i.e., burning, dull ache) ____________
Intensity level: 0 1 2 3 4 5 6 7 8 9 10
Freq./Duration ____________
Aggravating/Relieving Factors: ____________
Pain Management History ____________
Patient is prone to FALL: ❑ No ❑ Yes: ____________
❑ Fall risk assessment conducted every ____________ ❑ NO PROBLEM
❑ Fall prevention program in place, patient instructed SG
Comment: ____________

HOME ENVIRONMENT SAFETY

Safety hazards in the home: (check all that apply)

Hazard	Y	N
Fire alarm/smoke detector /Fire extinguish	❑	❑
Inadequate heating/ cooling/ electricity / lighting	❑	❑
Hurricane, Disaster Emergency supplies/kits	❑	❑
First aid box/Emergency Equipment or Supplies	❑	❑
Unsafe gas/electrical appliances or electrical outlets	❑	❑
Inadequate running water, plumbing problems	❑	❑
Unsafe storage of supplies/ equipment/ HME	❑	❑
No telephone available and/or unable to use the phone	❑	❑
Pest problems, Insects/rodents	❑	❑
Medications stored safely, clearly-easy use	❑	❑
Emergency planning, Exit Plan in place, more than one exit	❑	❑
Enough Ventilation	❑	❑
Safe Beds/Chairs, clear pathways	❑	❑
Able to follow directions in case of Emergency	❑	❑
Slippery Floors, Ashtrays (if a smoker)	❑	❑
Plan for power failure, emergency lights, flashlights, etc.	❑	❑
Relevant medical appliances, if applicable (wheelchair, O_2, Monitors, etc.)	❑	❑
Hurricane Shutter , Disaster Plan	❑	❑

ENTERAL FEEDINGS - ACCESS DEVICE - IV

❑ TPN ❑ Nasogastric ❑ Gastrostomy ❑ Jejunostomy ❑ Feeding type: ____________
Device: ❑ IV: ____________
❑ Pump: (type/specify) ____________ ❑ Bolus ❑ Continuous
Financial ability to pay for medications/insurance covered: ❑ Yes ❑ No
Comment: ____________ ❑ N/A

PATIENT/CLIENT NAME - Last, First, Middle Initial | Med. Record #

SAMPLE 305.818.5940

If the patient continue experiment: (21)
-ADL/IADL Deficit - Elimination Deficit - Impaired Mobility:
Indications for Home Health Aide may be continued:

MD Order obtained: ❑ Yes ❑ No Patient/Family: ❑ Refused

❑ N/A (Home Health Aide Services not needed)

Other Services ordered: ❑ SN ❑ MSW ❑ PT ❑ OT ❑ ST

❑ Comment: ____________________

SN or _____ - ORDERS - FREQUENCY/DURATION: ____________

AIDE - ORDERS - FREQUENCY/DURATION: ____________

❑ TUB/SHOWER BATH ❑ WASH CLOTHES ❑ OTHER: ____________
❑ PERSONAL CARE ❑ LIGHT HOUSEKEEPING
❑ HAIR COMB ❑ ASSIST TO DRESS
❑ ORAL HYGIENE ❑ PERI CARE
❑ TPR ❑ ASSIST WITH PERSONAL CARE AND ADL'S
❑ REPORT SIGNIFICANT FINDING TO AGENCY/CASE MANAGER

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

ACTIVITY	PRIOR Level of Function	I	A	D	COMMENTS (who assists, assistive device used, etc.)	60 DAYS SUMMARY IN THE PREVIOUS PERIOD
Eating/Kitchen access						
Transfer abilities						
Dressing/Grooming						
Bathing/ Personal Care						
Toileting/Hygiene abilities						
Ambulation/ROM						
Communication (verbal, non-verbal)						
Preparing/Serving light meals						
Preparing full meals						
Light housekeeping						
Personal laundry						
Handling money						
Using telephone						
Reading, Writing						
Hair care, Skin Care						
Managing Medications						
Other (Specify)						

GOALS (22)

❑ RETURN TO INDEPENDENT AMBULATION. BE SAFE IN SELF CARE.
❑ PATIENT WILL BE ABLE TO FUNCTION WITH ASSISTANCE OF CAREGIVER WITHIN HIS/HER CURRENT LIMITATIONS AT HOME.
❑ GOOD/FAIR RETURN TO PREVIOUS LEVEL OF ADLS INDEPENDENTLY.
❑ PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATIONS AT HOME.
❑ OTHER: ____________________

DISCHARGE PLANS

❑ WILL DISCHARGE THE PATIENT WITHIN ____ WEEKS, WHEN PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE PROPER CARE MANAGEMENT, NO S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
❑ OTHER: ____________________

Discussed with patient/client? ❑ Yes ❑ No REHAB POTENTIAL LEVEL: ____________

Instructions/Information Provided (Check all that apply):

❑ Patient Rights and responsibilities ❑ Do not resuscitate (DNR) (if applicable)
❑ State hotline/ABUSE number ❑ Service Agreement/Contract
❑ Advance directives information ❑ OASIS/HIPAA Privacy Notice, Confidentiality
❑ Emergency Plan, classification, instructions ❑ Medication sheet, instructions
❑ Agency phone numbers, address ❑ Home safety guidelines
❑ Client Information Handbook ❑ Alzheimer's, Fall prevention, Sensory impairments info
❑ Pain Management info ❑ Grievance Procedures
❑ Standard precautions /handwashing/ Infection Control
❑ Admission criteria, Information for Home visit, Services, Frequency
❑ Diabetes Control, other disease management information
❑ Care Plans ❑ Local Resources Guide ❑ Mission, ownership information
❑ Other ____________________

SAMPLE
305.818.5940

SKILLED INTERVENTION/SERVICE

☐ **Skilled Observation / Assessment** ☐ Foley Change/Care ☐ Patient Education/teaching ☐ Wound Care / Dressing Change ☐ Prep. / Admin. Insulin ☐ Diabetic Observation / Care
☐ INJECTION ROUTE:______ SITE: _____ MED. GIVEN: ____________ DOSE: _________ REACTION: ____________ ☐ Procedure/Tx well tolerated by Pt.
☐ Standard/Universal Precautions Followed ☐ Aseptic Tech. Used. ☐ Quality Control of Glucometer Performed ☐ Sharps Discarded Inside Sharps Container
☐ Correct handwashing technique followed (SG) ☐ Management/Evaluation Patient's Care Plan ☐ No caregiver/family available/willing to help patient with care, procedures.
❑ Other

DRUG REGIMEN REVIEW COMPLETED? ❑ Yes ❑ No
PATIENT/CLIENT/CAREGIVER RESPONSE ____________________

SUMMARY CHECKLIST

MEDICATION STATUS: ❑ No change ❑ Order obtained ❑ PRN order obtained
MEDICATION SCHEDULE/RECORD FILL OUT? ❑ Yes ❑ No (10)
CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ ST ❑ MSW
❑ SN ❑ Aide ❑ Other (specify) ____________________

SIGNATURES/DATES

X ____________________ ___/___/___
Patient/Client/Caregiver (optional if weekly is used) *Date*

____________________ ___/___/___
Professional signature/title *Date*

PATIENT/CLIENT NAME - Last, First, Middle Initial

Med. Record #