

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 _____

PATIENT/CLIENT NAME - Last, First, Middle Initial

ACTIVITIES PERMITTED

- 1 -Complete bedrest 8-Crutches CMS 485 (POC): **18B**
- 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

- 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**

ID#

SAFETY MEASURES

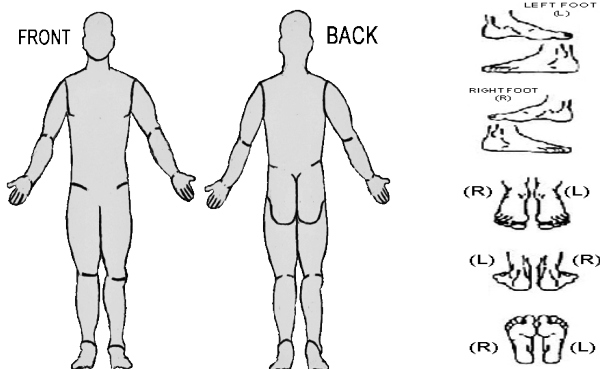
Safety Measures: CMS485 (POC) 15

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

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.



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: _____

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

ALLERGIES

- None known / NKA Aspirin Eggs Insect bites **17**
 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

HOME ENVIRONMENT SAFETY

- Safety hazards in the home: (check all that apply)**
- | | |
|--|---|
| Fire alarm/smoke detector /Fire extinguish | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Inadequate heating/ cooling/ electricity / lighting | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Hurricane, Disaster Emergency supplies/kits | <input type="checkbox"/> Y <input type="checkbox"/> N |
| First aid box/Emergency Equipment or Supplies | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Unsafe gas/electrical appliances or electrical outlets | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Inadequate running water, plumbing problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Unsafe storage of supplies/ equipment/ HME | <input type="checkbox"/> Y <input type="checkbox"/> N |
| No telephone available and/or unable to use the phone | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Pest problems, Insects/rodents | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Medications stored safely, clearly-easy use | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Emergency planning, Exit Plan in place, more than one exit | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Enough Ventilation | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Safe Beds/Chairs, clear pathways | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Able to follow directions in case of Emergency | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Slippery Floors, Ashtrays (if a smoker) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Plan for power failure, emergency lights, flashlights, etc. | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Relevant medical appliances, if applicable (wheelchair, O2, Monitors, etc.) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Hurricane Shutter , Disaster Plan | <input type="checkbox"/> Y <input type="checkbox"/> N |

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 #

If the patient experiment:

-ADL/IADL Deficit - Elimination Deficit - Impaired Mobility:

Indications for Home Health Aide may be needed:

- 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: _____

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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.)
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: _____

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 _____

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: _____

SKILLED NURSING 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.

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

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
 _____ /_____/_____
 Nurse signature/title Date

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