

SG Safety Goal
POC (CMS - 485) Box

COMPREHENSIVE ADULT SOC 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

TIME IN _____ TIME OUT _____
 DATE ___/___/___

Certification Period: **3**
 From ___/___/___ To ___/___/___

Provider Number: _____ **5** Agency Name: _____ **7**
 Physician name: _____ Phone: _____
 Address: _____ **24** Employee's Name/Title Completing the Assessment: _____
 Phone Number: _____
 PHYSICIAN: Date last contacted: ___/___/___ Date last visited: ___/___/___ Reason: _____

Other Physician (if any): _____
 Address: _____
 Phone Number: _____
 REFERRAL SOURCE (if not from Primary Physician): Referral date: ___/___/___
 N/A
 Phone: _____ Fax: _____

Emergency/Disaster Plan Classification Code: _____
EMERGENCY CONTACT:
 Address: _____
 Phone: _____ Relationship: _____
 OTHER: _____
 Evacuation Form needed? Emergency Registration Completed (please document)

CHIEF COMPLAINT: _____
 PRESENT ILLNESS/DIAGNOSIS: _____
 PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES: Diabetes
 Hypertension Cardiac Respiratory Osteoporosis Insulin Dependent
 Fractures: _____ Cancer (site: _____) Non-Insulin Dependent
 Immunosuppressed Open Wound Surgeries: _____
 Other: _____ Infection
 PREVIOUS OUTCOMES: _____

<p>DIAGNOSIS: Primary & Other Diagnosis 12</p> <p>_____ (_____) Date ___/___/___</p> <p>_____ (_____) Date ___/___/___</p> <p>_____ (_____) Date ___/___/___</p> <p>_____ (_____) Date ___/___/___</p> <p>_____ (_____) Date ___/___/___</p> <p>_____ (_____) Date ___/___/___</p> <p>_____ (_____) Date ___/___/___</p> <p style="text-align: center;">Surgical Procedure 12</p> <p>_____ (_____) Date ___/___/___</p> <p>_____ (_____) Date ___/___/___</p>	<p>VITAL SIGNS: Blood Pressure: <input type="checkbox"/> Sitting/lying R _____ <input type="checkbox"/> Standing R _____ L _____ Temperature: _____ L _____ <input type="checkbox"/> Rest <input type="checkbox"/> Activity <input type="checkbox"/> Oral <input type="checkbox"/> Axillary <input type="checkbox"/> Cheynes Stokes <input type="checkbox"/> Rectal <input type="checkbox"/> Tympanic Pulse: <input type="checkbox"/> Apical _____ <input type="checkbox"/> Brachial _____ <input type="checkbox"/> Radial _____ <input type="checkbox"/> Carotid _____ Respirations: _____ <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Death rattle <input type="checkbox"/> Apnea periods -sec. <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Accessory muscles used</p> <p>RECENT HOSPITALIZATION? <input type="checkbox"/> No <input type="checkbox"/> Yes, dates _____ - _____ Reason: _____ New diagnosis/condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____ IMMUNIZATIONS: <input type="checkbox"/> Up-to-date <input type="checkbox"/> H1N1 Needs: <input type="checkbox"/> Influenza <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tetanus <input type="checkbox"/> Other (specify) _____</p>
<p>Emergency/Disaster Plan Classification Code: _____</p>	<p>Patient ID Number: _____ 4 (Medical Record) 6 Patient Name: _____ Address: _____ 6 _____ Patient Phone: _____ <input type="checkbox"/> ALF / AFHC (circle) Social Security Number: _____ Name: _____ 1 _____ Phone: _____ Medicaid Number: _____ 1 Birth Date: ___/___/___ 8 Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female 9</p>

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

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PROGNOSIS: **20**

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

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

SYSTEM REVIEW

VISION	<input type="checkbox"/> Glasses	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Jaundice
	<input type="checkbox"/> Contacts: R / L	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Ptosis
	<input type="checkbox"/> Prosthesis: R / L	<input type="checkbox"/> Legally blind	
	<input type="checkbox"/> Infections		

Cataract surgery: Site _____ Date _____/_____/_____
 Other (specify, incl. hx) _____

NO PROBLEM

EARS	<input type="checkbox"/> HOH: R / L	<input type="checkbox"/> Deaf: R / L	<input type="checkbox"/> Hearing aid: R/L
	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Tinnitus	
	<input type="checkbox"/> 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	<input type="checkbox"/> Congestion	<input type="checkbox"/> Epistaxis	THROAT	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Hoarseness
	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Sinus prob.		<input type="checkbox"/> Lesions	<input type="checkbox"/> Sore throat
	<input type="checkbox"/> Nose surgery: _____			<input type="checkbox"/> Other (specify, incl. hx) _____	

Other (specify, incl. hx) _____

NO PROBLEM

MOUTH	<input type="checkbox"/> Dentures: Upper /Lower /Partial	<input type="checkbox"/> Masses/Tumors	
	<input type="checkbox"/> Gingivitis	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Toothache
	<input type="checkbox"/> 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

FUNCTIONAL LIMITATIONS 18A

<input type="checkbox"/> 1 -Amputation	<input type="checkbox"/> 4-Hearing	<input type="checkbox"/> 7-Ambulation	<input type="checkbox"/> A -Dyspnea with
<input type="checkbox"/> 2-Bowel/Bladder (incontinence)	<input type="checkbox"/> 5-Paralysis	<input type="checkbox"/> 8-Speech	
<input type="checkbox"/> 3 - Contracture	<input type="checkbox"/> 6-Endurance	<input type="checkbox"/> 9-Legally blind	

B- Other (specify) _____

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

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.

O₂ Sat. _____
 O₂ use: _____ L/rnin. by Mask Nasal Trach
 Gas Liquid Concentrator

Oxygen Precaution/Fire Prevention followed/explained to patient **SG**
 Other (specify, incl. hx) _____

NO PROBLEM

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 # _____
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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.
Table with 2 columns: Question, 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
Reprinted with permission by the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association and the National Council on the Aging, Inc., and funded in part by a grant from Ross products Division, Abbott Laboratories Inc.

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

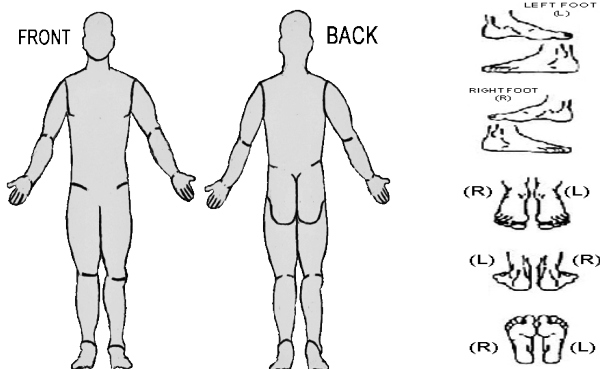
Safety Measures: CMS485 (POC) 15

- | | | | | |
|--|---|--|--|--|
| <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: _____

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 |

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

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: _____

21

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 SIS 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 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 _____

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 # _____