Cari Home Care, Inc.

NURSING ASSESSMENT

Kepro Submission Questionnaire

START OF CARE DATE: _____ Month Day Year	MEDICAL RECORD NUMBER
PATIENT NAME: _____ (Last) (First) (Middle)	PATIENT ADDRESS: _____ _____
BIRTH DATE: _____ (Month) (Day) (Year) GENDER: ___ Male ___ Female	PATIENT PHONE: ( )
PHYSICIAN INFORMATION: Physican Name: _____ Office Address: _____ Off. Phone/fax: _____	PHYSICIAN'S INFORMATION: Physician Nam_____ Office Address: _____ Off. Phone/fax: _____
PATIENT EMERGENCY CONTACT INFORMATION: Last Name, Name: _____ Relationship: _____ Phone Number: _____	SURANCE INFORMATION: Soci Security Number: _____ Medicaid Number: _____ Medicare Number: _____

PRIMARY DIAGNOSIS:	ICD	DATE
_____	_____	_____
SURGICAL PROCEDURES:		
_____	_____	_____
OTHER DIAGNOSIS		
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vital Signs: B/P: _____ Temp: _____ Pulse: _____ Resp: _____ Weight: _____ Height: _____

Comments: _____

_____

Patient Name: _____ MR#: _____

1. **IF THIS IS THE FIRST TIME THAT YOU ARE ENTERING A CASE FOR THIS PERIOD, complete the ENTIRE questionnaire. The information entered in the questionnaire, must be consistent with the Plan of Care.**
   □ OK

2. **If this is a RECERTIFICATION, Complete only the sections that have CHANGED within the past 60 days, the START OF CARE DATE (Question), the ANNUAL NURSING ASSESSMENT DATE (Question).**
   □ Ok

3. **Is this a RECERTIFICATION request for SKILLED NURSING visits for MEDICATION ADMINISTRATION? If so, complete question.**
   □ Yes □ No

4. **Is this a RECERTIFICATION request for SKILLED NURSING visits for WOUND CARE? If so, complete questions.**
   □ Yes □ No

5. **Source of Referral to Home Health Services (Check one)**
   □ Family Member □ Hospital □ Physician's Office □ Social Worker - Not Hospital Social Worker
   □ Other (describe) _____

6. **Source of Referral: Other/Describe**
   _____
   _____
   _____

7. **Medication 1 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
   _____

8. **Medication 2 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
   _____

9. **Medication 3 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
   _____

10. **Medication 4 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
    _____

11. **Medication 5 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
    _____

12. **Medication 6 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
    _____

13. **Medication 7 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
    _____

14. **Medication 8 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
    _____

15. **Medication 9 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**
    _____

16. **Medication 10 Enter Name/Dose/Frequency/Route; Indicate (N) for Medication prescribed within 30 days of start date of this CERT period or (C) for dosage Changes**

_____

17. **IF MORE THAN 10 MEDICATIONS, LIST REMAINDER IN EXCHANGE NOTES.**
□ Ok

18. **Medication administration (Check one) (MO780)**
□ No assistance needed □ Requires reminders □ Requires set-up □ Totally dependention another source

19. **DME & Supplies**:

___ Medical Supplies ___ Surgical Supplies ___ Hoyer Lift ___ Bedside Commode
___ Urinal ___ Cane ___ Shower chair ___ Walker
___ Wheel chair ___ Bathroom safety rails ___ None
___ Other (describe): _____

20. **DME & Supplies, Other: Description:**

_____

21. **Current diet (Check all that apply)** ___ Regular ___ Low Fat ___ PEG tube feeding ___ Diabetic
___ NG tube feeding ___ tube ___ Low sodium
___ Other (describe): _____

22. **Current diet, Other: Description**

_____

23. **Meal Preparation (Check all that apply) (MO430)** ___ Independent
___ Requires assistance w/ meal preparations
___ Requires assist w/ feeding and/or preparation

24. **Functional limitations:** (Check all that apply. If the item selected is followed by * describe in other)
___ Amputation* ___ Contracture ___ Hearing ___ Paralysis* ___ Endurance
___ Speech ___ Bowel/Bladder incontinence ___ Ambulation
___ Visual impair (glasses, poor, vision) ___ Legally blind ___ Dyspnea w/ minimal exertion

25. **Functional limitations: Other/Describe**

_____
_____

26. **Activities permitted (Check all that apply)** ___ Completed bedrest ___ Bedrest w/ BRP
___ Up as tolerated ___ Transfer bed/chair
___ Exercises prescribed ___ Partial weight bearing
___ Independent at home ___ Crutches ___ Cane
___ Wheelchair ___ Walker ___ No restrictions

27. **Activities permitted, Other: Describe**

_____

28. **Mental status (check all that apply):** □ Alert □ Oriented to time
□ Oriented to place □ Oriented to person □ Confused □ Disoriented
□ Lethargic □ Agitated _____

29. **Mental status, Other: Describe**

_____

30. **Caregiver (Check all that apply) (MO350, MO360) (IF NONE, SKIP TO QUESTION 35)**
□ None □ Lives alone □ ALF staff □ Spouse □ Daughter/Son □ Mother/Father
□ Grandparent □ Relative

31. **Caregiver, Other: Describe**

_____

32. **Caregiver availability/assistance (Check one)**
□ Able to assist w/ ADLs but not pericare □ Able but refuses □ Able to assist w/ care evenings only
□ Able to assist w/ care weekends only □ Able to assist evenings & weekends
□ Able to assist but overwhelmed

33. **Caregiver unavailability/unable to assist (Check one) (MO370, MO380)**
□ Unable to assist physical limitations □ Unavailable - school or paid employment

34. **Caregiver unavailability/unable to assist, Other: Describe**

_____

35. **Pain status (Check one) (If no pain skip to question 40):** ___ No pain ___ Intermittent pain
___ Constant pain

36. **Pain location (Check all that apply):** ___ Joint pain ___ Back pain ___ Upper extremity pain
___ Lower extremity pain

37. **Pain location, Other: Describe**

_____

38. **Pain control therapy (Check one):** Yes (describe) ___ No ___

39. **Pain control therapy: Describe**

_____

40. **Respiratory status (Check all that apply) (MO490) (If "No respiratory problems" is checked, skip to question 44):**
___ No respiratory problems ___ SOB w/ ambulation less than 20 feet
___ SOB at rest ___ SOB w/ ambulation greater than 20 ft
___ SOB while performing ADL's ___ Requires oxygen
___ Therapy PRN ___ Requires continuous oxygen therapy
___ Orthopnea x ___ pillows ___ Tracheostomy

41. **Respiratory status, Other: Describe**

_____

42. **Is this respiratory condition currently being treated? (Check one)** □ Yes (describe) □ No

43. **Respiratory condition treatment: Describe**

_____

44. **SKILLED NURSE visits ordered (Check one) - IF NO, SKIP TO QUESTION 59.** □ Yes □ No

45. **Visit frequency/duration (Check one) - IF OTHER, DESCRIBE IN QUESTION 47.**
□ 1w9 □ 2w9 □ 3w9 □ 4w9 □ 5w9 □ 6w9 □ 7w9 □ Other (describe)

46. **Daily visit frequency (Check one) - IF OTHER, DESCRIBE IN QUESTION 47.**
□ QID □ BID □ TID □ QID □ Other (describe)

47. **Visit frequency/duration, Other: Describe**

_____

48. **Treatment/procedures (Check all that apply) - Skilled observation and assessment excludes the initial/start of care and discharge assessments. IF THE ITEM SELECTED IS FOLLOWED BY *, GO TO QUESTION 49.**
□ Skilled observation and assessment □ Medication administration* (describe)
□ Instruct in disease process □ Instruct in medication regimen □ Instruct in diet/nutrition
□ Instruct/perform glucose monitoring □ Instruct/perform wound care* (describe)
□ Instruct/perform feedings care □ Instruct/perform colost. and/or ileostomy care
□ Instruct/perform bowel program* (describe) □ Instruct/perform tracheostomy care
□ Insert, remove and/or irrigate catheters □ Perform lab draws/venipuncture* (describe)
□ Monitor medication compliance
□ Other* (describe)

49. **Describe Treatment/procedures. IF MEDICATION ADMINISTRATION: drug name & duration. IF LAB DRAWS: test name & frequency. IF BOWEL PROGRAM: describe.**

_____

50. **For initial/recerts for SN visits for administration of SQ/IM meds: patient/caregiver unable to perform due to (Check all that apply). If no injectable meds, skip to question 53.**

□ Recipient with learning disability □ Recipient visually impaired
□ Recipient with impaired manual dexterity □ Recipient with hand deformities
□ Recipient unable to manipulate syringe □ Caregiver with learning disability
□ Caregiver with visual impairement □ Caregiver with impaired manual dexterity
□ Caregiver with hand deformities □ Caregiver unable to manipulate syringe □ No caregiver

51. **What measures has the agency undertaken to assist the RECIPIENT in becoming independent with injectible medication administration? Please describe.**

_____
_____
_____

52. **What measures has the agency undertaken to assist the CAREGIVER in becoming independent with injectible medication administration? Please describe.**

_____
_____
_____

53. **For Initial requests and recert: Laboratory tests cannot be performed elsewhere other than the recipient's home due to the following: (Check one)** □ Ambulatory status □ Lack of transportation
□ Needs assistance from house to vehicle □ Other (describe): _____
_____

54. **Laboratory tests cannot be performed outside home, Other: Describe**

_____

55. **Impairment in skin integrity (Check one) - PLEASE DESCRIBE ALL SELECTIONS IN NEXT THREE QUESTIONS. (MO440, MO468, MO482)**

□ Surgical incision (MO482) □ Open wound □ Pressure ulcer (MO445) □ Skin lesion (MO440)
□ Other: _____

56. **Impairment in skin integrity: Describe LOCATION (MO450, MO460, MO464, MO470, MO474, MO476, MO486, MO488)**

_____
_____
_____
_____

57. **Impairment in skin integrity: Describe MEASUREMENTS**

_____
_____
_____

58. **Impairment in skin integrity: Describe TREATMENT of impairment**

_____
_____
_____

59. **Home Health AIDE (HHA) visits ordered (Check one) IF NO SKIP TO QUESTION 79:** Yes ___ No ___

60. **Daily visit frequency (Check one) - DESCRIBE OTHER IN QUESTION 62.**

□ 1w9 □ 2w9 □ 3w9 □ 4w9 □ 5w9 □ 6w9 □ 7w9 □ Other (describe)

61. **Daily visit frequency (Check one) DESCRIBE IN QUESTION 62.**

□ QID □ BID □ TID □ QID □ Other (describe)

62. **Visit frequency/duration, Other: Describe**

_____

63. **Who assisted the recipient with personal care prior to home health services? Please describe.**

_____
_____
_____

64. **Who assists the recipient when the aide is not present? Please describe.**

_____
_____
_____

65. **Type of assistance to be provided by HHA ON 1st VISIT OF THE DAY (Check all that apply) - IF THE ITEM SELECTED IS FOLLOWED BY *, PLEASE COMPLETE QUESTIONS 74 THRU 78.**
□ Bathing □ Dressing □ Oral care □ Skin care □ Foot care □ Assistance with ambulation
□ Assistance with transfers □ Incontinent care* □ Perineal care □ Shave □ Obtain TPR

66. **Type of assistance to be provided by HHA on 2nd VISIT OF THE DAY (Check all that apply) - IF THE ITEM SELECTED IS FOLLOWED BY *, PLEASE COMPLETE QUESTIONS 74 THRU 78.**
□ Bathing □ Dressing □ Oral care □ Skin care □ Foot care □ Assistance with ambulation
□ Assistance with transfers □ Incontinent care* □ Perineal care □ Shave □ Obtain TPR

67. **Type of assistance to be provided by HHA on 3rd VISIT OF THE DAY (Check all that apply) - IF THE ITEM SELECTED IS FOLLOWED BY *, PLEASE COMPLETE QUESTIONS 78 THRU 78.**
□ Bathing □ Dressing □ Oral care □ Skin care □ Foot care □ Assistance with ambulation
□ Assistance with transfers □ Incontinent care* □ Perineal care □ Shave □ Obtain TPR

68. **Type of assistance to be provided by HHA on 4th VISIT OF THE DAY (Check all that apply) - IF THE ITEM SELECTED IS FOLLOWED BY *, PLEASE COMPLETE QUESTIONS 74 THRU 78.**
□ Bathing □ Dressing □ Oral care □ Skin care □ Foot care □ Assistance with ambulation
□ Assistance with transfers □ Incontinent care* □ Perineal care □ Shave □ Obtain TPR

69. **Bathing (Check one) (MO670)**
□ Independent - requires no assistance □ Requires assistance □ Completely dependent

70. **Dressing upper body (Check one) (MO650)**
□ Independent - requires no assistance □ Requires assistance □ Completely dependent

71. **Dressing lower body (Check one) (MO660)**
□ Independent - requires no assistance □ Requires assistance □ Completely dependent

72. **Ambulation (Check one) (MO700)**
□ Independent - requires no assistance □ Requires use of assistive device □ Requires human assistance
□ Requires both device & human assistance □ Uses walls and furniture for support □ Does not ambulate

73. **Transfer (Check one) (MO690)**
□ Independent - requires no assistance □ Requires use of assistive device □ Requires human assistance
□ Requires both device & human assistance □ Uses walls and furniture for support □ Does not ambulate

74. **Incontinence (Check one) - IF NO, SKIP TO QUESTION 79. (MO520, MO540)**
□ Yes □ No

75. **Degree of Incontinence (Check all that apply) - IF OTHER, DESCRIBE IN NEXT QUESTION.**
□ Bowel incontinence □ Urge incontinence □ Stress incontinence
□ Bladder incontinence during day & night □ Bladder incontinence at night only
□ Other (describe): _____

76. **Degree of incontinence, Other: Describe**

_____
_____

77. **Management of incontinence (Check all that apply) - IF OTHER OR MARKED BY *, DESCRIBE IN NEXT QUESTION. (MO520)**
□ Diapers □ Not independent changing diapers*
□ Urinal □ External catheter □ Indwelling catheter
□ Intermittent catheterization □ Suprapubic catheter □ Timed voiding
□ Other (describe): _____

78. **Management of incontinence, Other: Describe**
_____
_____

79. **Has the recipient been hospitalized in the past 60 days? If yes, please describe in next question.**
□ Yes □ No

80. **Reason for hospitalization: Describe, include diagnosis code.**
_____
_____

81. **Has the recipient been seen in an emergency room in the past 60 days? If yes, please describe in next question.**
□ Yes □ No

82. **Reason for emergency room visit: Describe**
_____
_____

83. **Has this recipient been seen by a primary provider in the past 90 days?** □ Yes □ No

84. **Start of care date - provide the date that your agency began providing services to the recipient (mm/dd/yy) (MANDATORY)** _____

85. **Initial nursing assessment date if this is an initial request (mm/dd/yy)** _____
providing services to this recipient for 12 consecutive months (mm/dd/yy) _____

86. **Plan of Care (485) Physician Signature Date (mm/dd/yyyy) (MANDATORY)** _____

_____ _____
RN SIGNATURE **DATE**