PATIENT REFERRAL INFORMATION

Med. Record ____________________

HIC ____________________ SOC ____________ CERT PERIOD______________________________

PATIENT NAME ____

EFFECTIVE DATE: ____________ DOB ______________ SEX _____ MARITAL STATUS __________

REF. TO: _________________________ TEAM LEADER___________________________________

STREET ______________________________________ PRIM. LANG. ____________________

CITY_____________________________ COUNTY __________ STATE______ ZIP ____________

PREVIOUS ADMIT ________________ NON-ADMIT__________ TELEPHONE (   )____________

2ND TELEPHONE (   )__________________ LIVES WITH __________________________________

EMERGENCY ____________________________________ CAREGIVER ______________________

Relation: _____________________ phone: ______________ ☐ Medicare ☐ Medicaid ☐ Other __________

DIAGNOSIS:

ICD-9CM _________ PRINCIPAL DIAGNOSIS _____________________________DATE __________

ICD-9CM _________ SURGICAL PROCEDURE _____________________________ DATE __________

OTHER PERTINENT DIAGNOSIS:

ICD-9CM _________ OTHER DIAGNOSIS _________________________________DATE __________

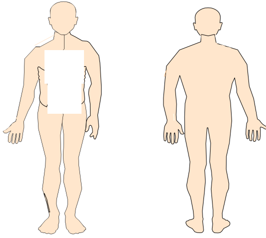
ICD-9CM _________ OTHER DIAGNOSIS _________________________________DATE __________

ICD-9CM _________ OTHER DIAGNOSIS _________________________________DATE __________

ICD-9CM _________ OTHER DIAGNOSIS _________________________________DATE __________

Past Medical Hx:____

____



Wound/Decubitus/Dressing:

Location	Size	Color	Drainage	Treatment

Sample 305.818.5940

MEDICATIONS	STRENGTH	DOSAGE	FREQUENCY	ROUTE	N/C

DME Company ______________________________ Nutritional Status ______________________________

Equipment _________________________________ ☐ G-Tube ☐ Ng-Tube

Safety Measures: ___________________________ Allergies:_____________________________________

Initial Verbal MD Order Date _________________ Last M.D. Visit_______________________ ☐ Face to Face done

Physician's Name: ______________________________________ Phone: (   ) _____________________

Street Address _________________________________ City, State, ZC: ___________________________

License:_____________ ☐ Verified Medipass:__________ Upin: ____________ NPI: __________________

PATIENT REFERRAL INFORMATION

PATIENT NAME ______________________________________ Med. Record ______________ SOC _____________

FUNCTIONAL LIMITATIONS:

__ Amputation
__ Bowel/Bladder Inct.
__ Contracture
__ Hearing
__ Paralysis
__ Endurance
__ Ambulation
__ Speech
__ Legally blind
__ Dyspnea w/min exertion
__ Other (specify)

ACTIVITIES PERMITTED:

___ Complete bed rest
___ Bed Rest BRP
___ Up as tolerate
___ Transfer bed/chair
___ Exercise Prescribed.
___ Partial Wt. Bear
___ Indep. & home
___ Crutches
___ Cane
___ Wheelchair
___ Walker
___ No Restrictions

Homebound Status: ____

____

MENTAL STATUS: ____Alert ___ Oriented ___ Disoriented ___ Lethragic ___ Forgetful ___ Comatose
____ Depressed ___ Anxious ___ Agitated

PROGNOSIS: ___ Poor ___ Guarded ___ Fair ___ Good ___ Excellent

Vital Signs (if applicable): B/P________ P ________ R _________ T_________ Weight ________ Ht __________

Pharmacy ____ Telephone ( ) ___________________

Foley Cath (Y) (N) if (Y) Date inserted ___________________________

Lab Work ____ Frequency __________________________________

DISCIPLINE NAME **FREQUENCY**

Sign Up ___________________________________ ____

(SN)Follow-Up _____________________________ ____

HHA ____________________________________ ____

PT ____________________________________ ____

MSW ____________________________________ ____

OTHER __________________________________ ____

Referral Source

Hospital __________________________ Medical Office _____________________________ Other_______________

Admission _____________________ D/C Date ___________________

Preferred Hospital Name _________________________________ Other Agency involved _______________________

OTHER INSURANCE: Y ____ N ____

Name of Insured ____

SS # _______________________________ Ins. Co.: ____

Address ____________________________________ City: __________________ State: ________ Zip ____________

Phone: ( ) _______________________ Policy #: _________________________ Group # _______________________

Sample
305.818.5940

SG Safety Goal
POC (CMS - 485) Box

COMPREHENSIVE ADULT NURSING 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: __ __/__ __/ __ __ __ __ (month day year) (2)

Certification Period: (3)

From __/___/______ To___/___/______

TIME IN ________ TIME OUT ________

DATE ______/______/______

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:_______________

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: __ __/__ __/__ __ __ __ (3) **month / day / year** **Gender:** ❑ **Male** ❑ **Female** (9)

Emergency/Disaster Plan Classification Code: ________________

EMERGENCY CONTACT: ______________________________

Address: ______________________________

Phone: __________________ Relationship: __________

OTHER: ______________________________

Evacuation Form needed? Emergency Registration Completed (please document)

____

RECENT HOSPITALIZATION? ❑ No ❑ Yes, dates _______ - _______

Reason: ______________________________

New diagnosis/condition? ❑ No ❑ Yes, specify ____________________

IMMUNIZATIONS: ❑ Up-to-date ❑ H1N1

Needs: ❑ Influenza ❑ Pneumonia ❑ Tetanus ❑ Other (specify) ______________

CHIEF COMPLAINT: ______________________________

____

PRESENT ILLNESS/NURSING DIAGNOSIS: ____________________

PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES: ❑ Diabetes ❑ Insulin Dependent ❑ Non-Insulin Dependent

❑ Hypertension ❑ Cardiac ❑ Respiratory ❑ Osteoporosis

❑ Fractures: _____ ❑ Cancer (site:_______________)

❑ Immunosuppressed ❑ Open Wound ❑ Surgeries:____________

❑ Other:______________________________ ❑ Infection

VITAL SIGNS: **Blood Pressure:** ❑ Sitting/lying R _________ L _________ ❑ Standing R ________ L _________

Temperature:_________ ❑ Oral ❑ Axillary ❑ Rectal ❑ Tympanic

❑ Rest ❑ Activity ❑ Cheynes Stokes

Pulse: ❑ Apical______ ❑ Brachial ❑ Radial______ ❑ Carotid ______ ❑ Regular ❑ Irregular

Respirations: _________ ❑ Death rattle ❑ Apnea periods -sec. ❑ Regular ❑ Irregular ❑ Accessory muscles used

PREVIOUS OUTCOMES:______________________________

DIAGNOSIS:

Primary & Other Diagnosis (12)	ICD-9-CM (12)	Date
______________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________	(___ ___ ___ ___ ___)	Date ____/____/____

Surgical Procedure (12)	ICD-9-CM (12)	Date
______________________	(___ ___ ___ ___ ___)	Date ____/____/____
______________________	(___ ___ ___ ___ ___)	Date ____/____/____

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

Sample 305.818.5940

COMPREHENSIVE ADULT NURSING 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

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

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

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 1 0 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 ________

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**

❑ 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**

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. ____________

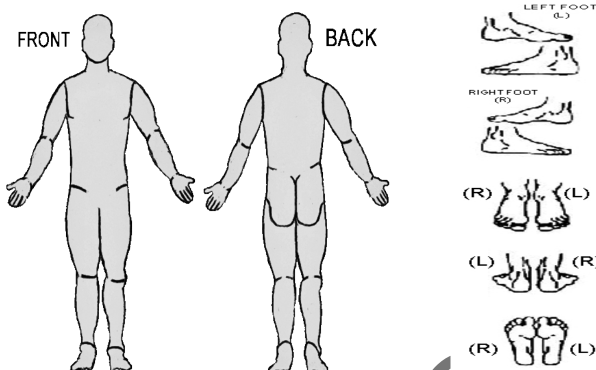
Phone: ____________

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

Sample 305.818.5940

If the patient experiment: (21)
-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: ______

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: ______

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 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 ______

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 #*

Sample
305.818.5940

RECERTIFICATION COMPREHENSIVE ADULT NURSING ASSESSMENT
WITH CMS 485 (POC) INFORMATION

SG Safety Goal
\# POC (CMS - 485) Box

☐ 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)

Employee's Name/Title Completing the Assessment: ______________________________

Phone Number: ______________________________

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 NURSING 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**

ACTIVITIES PERMITTED

CMS 485 (POC): 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) ____

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
❑ Syncope
❑ Sensory loss
❑ Numbness
❑ Impaired decision-making ability
❑ Oriented X ____
❑ Insomnia/Change in sleep pattern
❑ Vertigo
❑ Ataxia
❑ 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**

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**

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: ____________

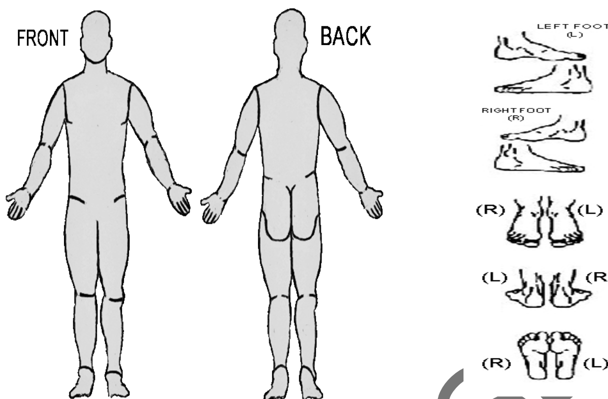
❑ Fire Alarm ❑ Smoke Alarm

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

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 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 ____________________

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 #*

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305.818.5940

Authority to Sign on Behalf of Patient

Autorización Para Firmar en Lugar del Paciente

The undersigned has the authority to sign documents for the following patient:

______________________________ ______________

Patient Name/*Nombre del Paciente* MR#

The reason for this authorization is as follows:

Patient is unable to sign because:__________________________________

____

____

The reason I am qualified to sign is (check one):

1. Guardianship - Attach copy of order appointing guardian. ☐
2. Relative - State exactly how related. ☐
3. Owner of Health Care Facility - State whether individual, partner, stockholder, director or officer, and state full name of facility. ☐
4. If other than above - State with specificity why you are empowered to sign. ☐

____

El abajo firmante tiene la autoridad para firmar documentos con referencia al paciente cuyo nombre está escrito arriba.

La razón por la cual esta autorización es necesaria es la siguiente:

El Paciente no puede firmar porque:

____

____

____

La razón por la cual tengo autoridad para firmar es (marque uno):

1. Tutela - *Agregue la copia de la orden asignando la tutela.* ☐
2. Familiar - *Especifique exactamente la relación.* ☐
3. *Dueño de un centro de cuidados médicos - Indique si es individual, asociado, director, accionista, u oficial, e indique el nombre completo del centro.* ☐
4. *Si hay otras razones que no sean las de arriba, indique especificamente porque usted tiene el poder de firmar.* ☐

____

______________________________ ______________

Signature/*Firma* Date/*Fecha*

______________________________ ______________

Witness/*Testigo* Date/*Fecha*

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Patient Name: ______________________________ **MR#** ____________________

Staff Change (Discipline: ____________)

Complete the following:

1. **The original** Employee/contracted ______________________________was changed on (date) _____________.

2. The new assigned Employee (name) ________________________________ was contacted on (date) _____________ and approved this change.

3. The reason for change was: ______________________________________
____
____

Sample
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Office staff (name) ____

______________________________ ______________________
Signature of Agency Representative Date

HOME HEALTH/HOME CARE AIDE WEEKLY VISIT RECORD

EMPLOYEE NAME/TITLE ______________________

EMPLOYEE NO. ______________

When completing be sure to follow the Aide Assignment Sheet/Care Plan

DAY-	SUN	MON	TUE	WED	THU	FRI	SAT	WEEK OF / SEMANA DE
DATE / FECHA								/ /
TIME IN / HORA DE ENTRADA:	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	THROUGH / A
TIME OUT/ HORA DE SALIDA:	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	/ /

	ACTIVITIES	SUN	MON	TUE	WED	THU	FRI	SAT	COMMENTS (All comments must be dated)
VITALS	T ______________								
	P __________ BP __________								
	R ______________								
	Weight-Peso / Pain Rating-Dolor (0 - 10 scale)								
BATH	Tub/Shower/ Bañera/Ducha								
	Bath: Bed/Sponge-Cama/Sponja - Partial/Complete								
	Assist Bath Chair/Asistir baño en silla								
HYGIENE/GROOMING	Personal Care/Cuidado Personal								
	Assist with Dressing/Asistir vestirse								
	Hair Care/Cuidado del cabello								
	Shampoo								
	Skin Care/Cuidado de la piel								
	Foot Care/Cuidado de los pies								
	Check Pressure Areas/Ulceras de presión								
	Nail Care/Cuidado de las uñas								
	Oral Care/Cuidado oral								
	Clean Dentures/Limpiar dentaduras								
	Shave / Afeitar								
	Other/Otro (specify):								
PROCEDURES	Assist with Elimination/Asistir eliminación								
	Catheter Care/Cuidado de catetes								
	Ostomy Care/Cuidar ostomia								
	Record Intake/Output-Registro tomar/salida								
	Inspect/Reinforce Dressing/Inspeccionar Vendas								
	Medication Reminder/Recordar medicinas								
	Other/Otro (specify):								
ACTIVITY	Assist with Ambulation - WC/Walker/Cane Ayudar con Ambulación, SillaRueda/Andador/Baston								
	Assist with Mobility: Chair Bed/ Dangle/Commode/Shower/Tub Asistir con mobilidad (silla,cama,cuña,pato,ducha,bañera)								
	ROM Active/Passive (Rango de Mov.Activo/Pasivo) Arm R/L Leg R/L								
	Positioning-Encourage Assist (Cambio de Posiciones) ______ hrs								
	Exercise Per PT/0T/SLP Care Plan/ Ejercicios por Plan de Cuidado								
	Other/Otro (specify):								
NUTRITION	Meal Preparation/Prep. de comida								
	Assist with Feeding/Asistir alimentar								
	Limit/Encourage Fluids - Limitar/Exigir Fluidos								
	Grocery Shopping/Comprar comida								
	Other/Otro (specify):								
OTHER	Wash Clothes/Lavar ropa								
	Light Housekeeping (Ligera limpieza)- Bedroom(cuardto)/Bath-room(baño)/Kitchen(cocina) - Change Bed Linen(cambiar sabanas)								
	Equipment Care/Cuidado de equipos								
	Other/Otro (specify):								
	Last Bowel Movement/Ultima vez al baño(necesidades)								

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS (Verifique la identidad del paciente por nombre,fecha de nacimiento y dirección)

☐ Communication with Agency (llamo al supervisor)/Supervisor: ______________________

EMPLOYEE SIGNATURE(Firma del empleado)/TITLE(Título)/DATE(Fecha):

Signature/Firma: ______________________ / / *Date/Fecha*

PATIENT/CLIENT NAME Last First Middle Initial (Nombre del paciente):

MR#

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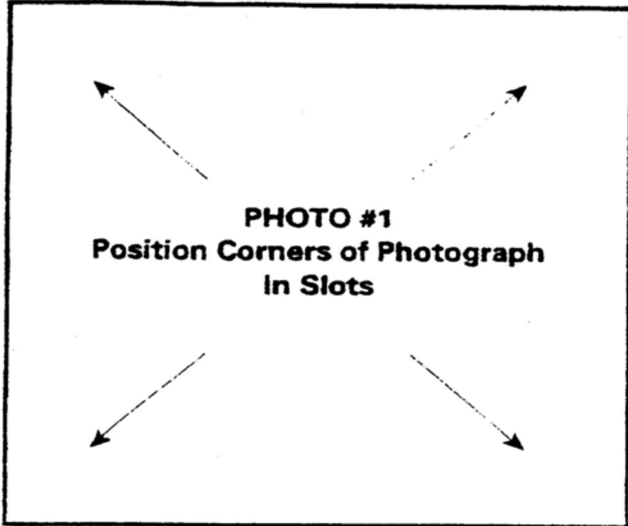
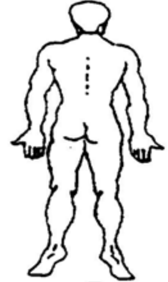
Photographic Wound Documentation

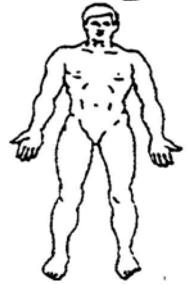


Date: ___________________

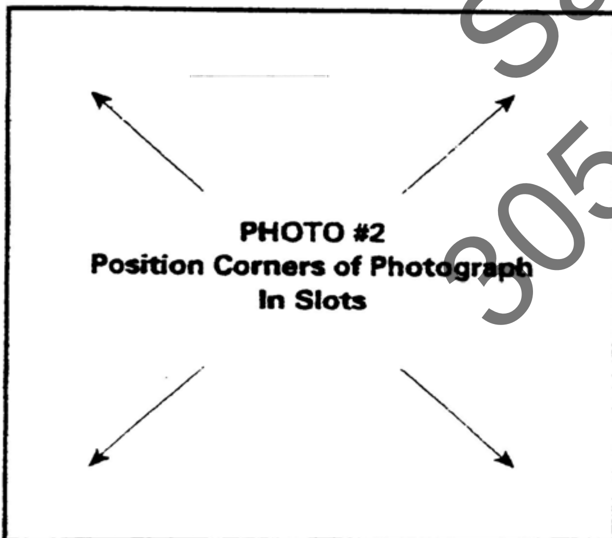
Picture Taken by:

____





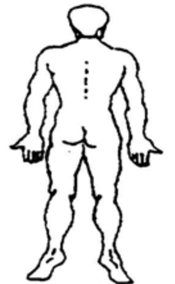
Sample
305.818.5940

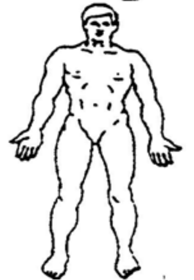


Date: ___________________

Picture Taken by:

____





Name: LAST	FIRST	MIDDLE	MED.RECORD #:

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

SOCIAL SERVICE
DATA BASELINE

GENERAL INFORMATION

Patient Name ______________________ DOB: __________ Sex: __________

Patients MR# ______________________ HIC # ______________________ Age: __________

Diagnosis ____

____

Prior Agency Admissions ____

Prior Referral to Social Services: Yes ____ No ____ If yes, but not seen explain: ______________

____

Reason for Present Referral to Social Service ____

____

PATIENT PROFILE

Patient's Understanding of Reason for Referral ____

____

Orientation: Time ______ Place __________ Pers ______ General Appearance __________

Place of Birth ______________________ Age came to U.S. __________

Emotional Tone ______________________ Motivation: Good ______ Poor ______ Guarded ______

Capacity to Cope with Present ____

Potential for Change- ____

FAMILY PROFILE / SOCIAL HISTORY

Marital Status S M W D # of Marriages __________ # of years __________

Children: ____

Address: ____

Significant Cult Mores ____

Communication bet Family ____

Patient and Family Knowledge ____

Household Members Health ____

Language ______________________ Religion ______________ Importance __________

Living Arrangement ______________________ Condition ______________________

S/0 involved in Patients Care ____

Source of income ______________________ Monthly Income ______________________

Insurance ______________________ Unmet Needs ______________________

PERSON TO BE CONTACTED

Name ______________________ Address ______________________

Phone ______________________ Relation ______________________

AGENCIES NEEDED FOR PATIENT AND/OR FAMILY

Agency ______________________ Ph ______________ Worker ______________

Agency ______________________ Ph ______________ Worker ______________

Agency ______________________ Ph ______________ Worker ______________

Comment:: ____

____

____

Signature ______________________________ Date ______________

Sample
305.818.5940

SOCIAL SERVICE NARRATIVE

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

PATIENT: ______________________ MR# ______________ HIC # __________

PATIENT:

FAMILY:

DIAGNOSTIC IMPRESSIONS OF SOCIAL WORKER:

TREATMENT GOAL:
INCLUDE COMMUNITY AGENCIES TO BE UTILIZED

SIGNATURE: ______________________ DATE: ______________

Sample
305.818.5940

MEDICAL SOCIAL SERVICES CARE PLAN

SOC DATE ____/____/____

REASON FOR VISIT/PROBLEM

____

MEDICAL SOCIAL SERVICES TREATMENT PLAN

PATIENT/CLIENT DESIRED OUTCOMES	SHORT TERM OUTCOMES Time Frame	LONG TERM OUTCOMES Time Frame

PLAN OF CARE

☐	Assessment of social and emotional factors (E1)	☐	Arrange transportation for medical appointments	☐	Services to family member(s)/caregiver(s) ____
☐	Counseling for long-range planning and decision making (E2)	☐	Emotional support to patient/client/family		
		☐	Financial resource information	☐	Referral to support group(s)/ community resource(s) (specify) ____
☐	Community resource planning (E3)	☐	Arrangement of meal services		
☐	Short term therapy (E4)	☐	Initiate abuse reporting mechanism		
☐	Identify eligibility for services/ benefits	☐	Initiate referral to personal emergency response system		
☐	Initiate counseling				
☐	Nursing home placement assistance	☐	Teach self-management skills	☐	Other:
☐	Alternate living arrangements	☐	Crisis intervention	☐	

COMMENTS/ADDITIONAL INFORMATION ______________________________________

PATIENT/CLIENT/CAREGIVER RESPONSE TO PLAN OF CARE ______________________________________

Sample 305.818.5940

SUMMARY

GOALS ACHIEVED? ☐ Yes ☐ No
Specify ______________________________________

REFERRALS COMPLETED? ☐ Yes ☐ No
Specify ______________________________________

CARE COORDINATION: ☐ Care Manager, date ____/____/____
☐ Physician, date ____/____/____ ☐ Other (specify) ____

APPROXIMATE NEXT VISIT DATE ____/____/____
PLAN FOR NEXT VISIT ______________________________________

DISCHARGE PLAN DISCUSSED WITH: ☐ Patient/Client/ Family
☐ Care Manager ☐ Physician ☐ Other ____
DISCHARGE INSTRUCTIONS GIVEN TO PATIENT/CLIENT/ FAMILY? ☐ No ☐ Yes, specify ____

SIGNATURES/DATES

X ______________________________ ____/____/____
Medical Social Worker (signature/title) *Date*

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

OCCUPATIONAL THERAPY CARE PLAN

☐ INITIAL
☐ UPDATED

Diagnosis/ Reason for OT:______________________ ONSET:__________

Frequency and Duration:______________________

INTERVENTIONS

Locator #21

	Evaluation		Fine motor coordination		Body image training
	Establish/ upgrade home exercise program ☐ Copy given to patient ☐ Copy attached to chart		Neuro-developmental training		Teach safe/effective use of adaptive/assist device (specify)
			Sensory treatment		
			Orthotics/Splinting		Muscle re-education
	Patient/Family education		Prosthetic training, Adaptive equipment, fabrication		Teach fall safety
	Perceptual motor training		Pain Management		Therapeutic exercise to __________ to increase strength coordination, sensation and proprioception
	Independent living/ADL training		Teach alternative bathing skills		
			Retraining of cognitive, feeding, and perceptual skills		Other:

Note: Each modality specify frequency, duration, amount: ______________________

SHORT TERM GOALS

- ☐ HEP will be established and initiated.
- ☐ Pain level will decreased from ___/10 to ___/10 within _____ weeks.
- ☐ Patient will be able to stand in kitchen to prepare meal for _____ min within______ weeks.
- ☐ Patient will be able to reach ______________ on ______________ within ______ weeks.
- ☐ Patient will be able to lift _____ # pounds from __________ to __________ within _______ weeks.
- ☐ Patient will be able to wash ______________________________ within ______ weeks.
- ☐ Patient will be able to reach a Cup from _________ and taked to _________ within ______ weeks.
- ☐ Patient will be able to integrate orthotic/prosthetic ___________ to ___________ within _____weeks.
- ☐ Patient will be able to don/doff _____________ with assistance of ___________ within _____weeks.

LONG TERM GOALS

Locator #22

- ☐ Patient will be able to finalize and demonstrate to follow up HEP.
- ☐ Pain level will decreased from ___/10 to ___/10 within _____ weeks.
- ☐ Patient will be able to stand in kitchen to prepare meal for ___ min within ____ weeks.
- ☐ Patient will be able to reach ___________ on ___________ within ______ weeks.
- ☐ Patient will be able to lift ____ # pounds from _________ to _________ within ______ weeks.
- ☐ Patient will be able to wash ______________________________ within ______ weeks.
- ☐ Patient will be able to reach a Cup from __________ and taked to __________ within ______ weeks.
- ☐ Patient will be able to use orthotic/prosthetic ____________ with/without assistance whitin _______ weeks.
- ☐ Patient will be able to don/doff __________________________ independently within _____weeks.

ADDITIONAL SPECIFIC OCCUPATIONAL THERAPY GOALS

Locator #22

Note: Each modality specify location, frequency, duration, and amount.

Patient Expectation	SHORT TERM Time Frame	LONG TERM Time Frame

DISCHARGE PLANS DISCUSSED WITH: ☐ Patient/Family ☐ Care Manager ☐ Physician ☐ Other (specify) __________

CARE COORDINATION: ☐ Physician ☐ PT ☐ SN ☐ ST ☐ MSW ☐ Aide ☐ OTA ☐ Other (specify) __________

SAFETY ISSUES/INSTRUCTION/EDUCATION:

APPROXIMATE NEXT VISIT DATE: __________________

PLAN FOR NEXT VISIT ______________________

COMMENTS/ADDITIONAL INFORMATION:

Equipment needed:______________________

Patient/Caregiver aware and agreeable to POC: ☐ Yes ☐ No (explain):______________________

GOALS: OCCUPATIONAL THERAPY

Locator #22

REHAB POTENTIAL: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

DISCHARGE PLAN: ☐ When goals met ☐ Other (specify) ______________________

Plan developed by: ______________________ ______________________ Date__________

Therapist Name Signature/title

Physician signature: ______________________ Date__________

Please sign and return promptly

Original - Physician Copy - Clinical Record (until signed original returned)

PATIENT NAME - Last, First, Middle Initial ID#

Sample 305.818.5940

OCCUPATIONAL THERAPY REVISIT NOTE

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

VITAL SIGNS: Temperature:__________ Pulse:__________ ☐ Regular ☐ Irregular Respirations:__________ ☐ Regular ☐ Irregular
Blood Pressure: Right______/______ Left______/______ ☐ Lying ☐ Standing ☐ Sitting
Pain: ☐ None ☐ Same ☐ Improved ☐ Worse Origin__________ Location(s)__________
Duration__________ Intensity 0 1 2 3 4 5 6 7 8 9 10______ Other:______ Relief measures__________

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) __________

TYPE OF VISIT:
☐ Revisit
☐ Revisit and Supervisory Visit
☐ Other (specify) __________
SOC DATE ____/____/____

TREATMENT DIAGNOSIS/PROBLEM AND EXPECTED OUTCOMES: __________

OCCUPATIONAL THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X".)

	Evaluation		Neuro-developmental training		Therapeutic exercise to right/left hand to increase strength, coordination, sensation and proprioception
	Establish home exercise program		Sensory treatment		
	☐ Copy given to patient		Orthotics/Splinting		
	☐ Copy attached to chart		Adaptive equipment (fabrication and training)		Teach fall safety
	Patient/Family education				Pain management
	Independent living/ADL training		Teach alternative bathing skills (unable to use tub/shower safely)		Other:
	Muscle re-education				
	Perceptual motor training		Retraining of cognitive, feeding and perceptual skills		
	Fine motor coordination				

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES: __________

EVALUATION AND PATIENT/CAREGIVER RESPONSE: __________

☐ Modality used ______	☐ Modality used ______	☐ Modality used ______
☐ Location ______	☐ Location ______	☐ Location ______
☐ Frequency ______	☐ Frequency ______	☐ Frequency ______
☐ Duration ______	☐ Duration ______	☐ Duration ______
☐ Intensity ______	☐ Intensity ______	☐ Intensity ______
☐ Other ______	☐ Other ______	☐ Other ______

CARE PLAN: ☐ Reviewed/Revised with patient involvement.
If revised, specify __________
☐ Outcome/Instruction achieved (describe) __________
☐ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ____/____/____
PLAN FOR NEXT VISIT __________
DISCHARGE PLANS DISCUSSED WITH: ☐ Patient/Family ☐ Care Manager ☐ Physician ☐ Other (specify) ______
BILLABLE SUPPLIES RECORDED? ☐ N/A ☐ Yes (specify)______
CARE COORDINATION: ☐ Physician ☐ PT ☐ SN ☐ ST ☐ MSW ☐ Aide ☐ Other (specify) ______

SUPERVISORY VISIT (Complete if applicable)
☐ OT Assistant ☐ Aide ☐ Present ☐ Not present
SUPERVISORY VISIT ☐ Scheduled ☐ Unscheduled
OBSERVATION OF __________
TEACHING/TRAINING OF __________
PATIENT/FAMILY FEEDBACK ON SERVICES/CARE (specify) __________
NEXT SCHEDULED SUPERVISORY VISIT ____/____/____
CARE PLAN UPDATED? ☐ No ☐ Yes (specify) ______
If OT assistant/aide not present, specify date he/she was contacted regarding updated care plan: ____/____/____

SIGNATURES/DATES

X __________ ____/____/____
Patient/Caregiver (if applicable) Date

Complete TIME OUT prior to signing below. Time In: ______ Time Out: ______
__________ ____/____/____
Therapist (signature/title) Date

PART 1 - Clinical Record PART 2 - Therapist

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

Sample 305.818.5940

OCCUPATIONAL THERAPY

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ____/____/____

TIME IN ________ OUT ________

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) ________

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ____/____/____
(if Initial Evaluation, complete Occupational Therapy Care Plan)

ORDERS FOR EVALUATION ONLY? ☐ Yes ☐ No If No, orders are ________

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/PROBLEM ________

________ ONSET ____/____/____

MEDICAL PRECAUTIONS ________

ACTUAL LEVEL OF FUNCTION (ADL / IADL) ________

PRIOR LEVEL OF FUNCTION (ADL / IADL) ________

LIVING SITUATION/SUPPORT SYSTEM ________

ENVIRONMENTAL BARRIERS ________

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY PROVIDED ________

KEY: I - Intact, MIN - Minimally Impaired, MOD - Moderately Impaired, S- Severely Impaired, U- Untested/Unable to Test

SENSORY/ PERCEPTUAL MOTOR SKILLS

Area	Sharp/Dull		Light/Firm Touch		Proprioception	
	Right	Left	Right	Left	Right	Left

VISUAL TRACKING:
R/L DISCRIMINATION:
MOTOR PLANNING PRAXIS:
Do sensory/perceptual impairments affect safety? ☐ Yes ☐ No
If Yes, recommendations:
COMMENTS:

COGNITIVE STATUS/COMPREHENSION

Area	I	MIN	MOD	S	U
MEMORY Short term					
Long term					
SAFETY AWARENESS					
JUDGMENT					
Visual Comprehension					
Auditory Comprehension					

ABILITY TO EXPRESS NEEDS
ATTENTION SPAN
ORIENTED: ☐ Person ☐ Place ☐ Time ☐ Reason for Therapy

PSYCHOSOCIAL WELL-BEING

INITIATION OF ACTIVITY
COPING SKILLS ☐ Evaluate Further
SELF-CONTROL

MOTOR COMPONENTS (Enter Appropriate Response)

Area	I	MIN	MOD	S	U	Area	I	MIN	MOD	S	U
FINE MOTOR COORDINATION (R)						GROSS MOTOR COORDINATION (R)					
FINE MOTOR COORDINATION (L)						GROSS MOTOR COORDINATION (L)					

PRIOR TO INJURY: ☐ Right Handed ☐ Left Handed ORTHOSIS: ☐ Used ☐ Needed (Specify):

MUSCLE STRENGTH/ FUNCTIONAL ROM EVALUATION (Enter Appropriate Response)

PROBLEM AREA	STRENGTH		ROM		ROM TYPE			TONICITY		OTHER DESCRIPTIONS
	Right	Left	Right	Left	P	AA	A	Hyper	Hypo	

COMMENTS: ________

PATIENT/CLIENT NAME: Last, First, Middle Initial | ID #:

OCCUPATIONAL THERAPY EVALUATION
☐ Continued

Sample 305.318.5340

OCCUPATIONAL THERAPY (Cont'd.)

☐ EVALUATION ☐ RE-EVALUATION

FUNCTIONAL MOBILITY/BALANCE EVALUATION

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
BED MOBILITY			DYNAMIC SITTING BALANCE		
BED/WHEELCHAIR TRANSFER			STATIC SITTING BALANCE		
TOILET TRANSFER			STATIC STANDING BALANCE		
TUB/SHOWER TRANSFER			DYNAMIC STANDING BALANCE		

SELF CARE SKILLS

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
FEEDING			TOILETING		
SWALLOWING			BATHING		
FOOD TO MOUTH			UE DRESSING		
ORAL HYGIENE			LE DRESSING		
GROOMING			MANIPULATION OF FASTENERS		

INSTRUMENTAL ADL'S

TASK	SCORE	COMMENTS	TASK	SCORE	COMMENTS
LIGHT HOUSEKEEPING			USE OF TELEPHONE		
LIGHT MEAL PREPARATION			MONEY MANAGEMENT		
CLOTHING CARE			MEDICATION MANAGEMENT		

PATIENT GOALS:

Sample 305.818.5940

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance
4	Good strength - against gravity with some resistance.
3	Fair strength - against gravity - no resistance - safety compromise.
2	Poor strength - unable to move against gravity.
1	Trace strength - slight muscle contraction - no motion.
0	muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

FUNCTIONAL INDEPENDENCE, SELF-CARE SKILLS AND INSTRUMENTAL ADL SCALE

GRADE	DESCRIPTION
5	Physically able and does task independently.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) - 100% patient/client effort.
2	Minimum assist (Min A) - 75% patient/client effort.
1	Maximum assist (Max A) - 25% - 50% patient/client effort.
0	Totally dependent - total

AVERAGE RANGES OF JOINT MOTION (ROM)

AREA	ACTION/ MOVEMENT			
Shoulder	Flex	158°	Extend	55°
	Abd.	170°	Add.	50°
	Int. rot.	70°	Ext. rot.	90°
Elbow	Flex	145°	Ext.	0°
Forearm	Sup.	85°	Pron.	70°
Wrist	Flex	73°	Ext.	70°
Fingers	Flex all	90°	Ext.	0°
Thumb	Abduction	50%		
Cervical	Flex	35°	Ext.	35°
Spine	Rotation	45°		

BALANCE SCALE (sitting-standing)

GRADE	DESCRIPTION
5	Independent
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA) - 100% patient/client effort.
2	Minimum assist (Min A) - 75% patient/client effort.
1	Maximum assist (Max A) - 25% patient/client effort.
0	Totally dependent for support.

FOR RE-EVALUATION USE ONLY:

IF A PREVIOUS PLAN OF CARE WAS ESTABLISHED, THEN IT WILL:

☐ CHANGE

☐ NOT CHANGE

PATIENT'S NAME: ______________________ MED. RECORD #: ______________

THERAPIST'S SIGNATURE/TITLE ______________ DATE __/__/__ PHYSICIAN'S SIGNATURE ______________ DATE __/__/__

** If no changes made to Initial Plan of care, MD signature no required.*

☐ INITIAL
☐ UPDATED

PHYSICAL THERAPY CARE PLAN

Diagnosis/ Reason for OT: ______ ONSET: ______
Frequency and Duration: ______

INTERVENTIONS

Locator #21

☐	Evaluation	☐	Balance training /activities	☐	Teach hip safety precautions
☐	Establish/ upgrade home exercise program	☐	Pulmonary Physical Therapy	☐	Teach safe/effective use of adaptive/assist device (specify)
	❑ Copy given to patient	☐	Ultrasound to _____ at _____ x _____ min		
	❑ Copy attached to chart	☐	Electrotherapy to _____ for _____ min	☐	Teach safe stair climbing skills
☐	Patient/Family education	☐	Prosthetic training	☐	Teach fall safety
☐	Therapeutic exercise	☐	TENS to _____ for _____ min	☐	Pulse oximetry PRN
☐	Transfer training with/without assistance	☐	Functional mobility training	☐	Heat/Cold to _____ for _____ min
☐	Gait training with/without assistance	☐	Teach bed mobility skills	☐	Therapeutic massage to _____ x _____ min

Note: Each modality specify frequency, duration, amount and specify location: ______

SHORT TERM GOALS

GENERAL
❑ Gait will increase tinetti gait score to _____ / 12 within ______ weeks.
❑ Will improve gait requiring ____ to _____ from _____ to ______ within ____ weeks.

BED MOBILITY
❑ Pt. will be able to turn side (facing up) to lateral (left/right) within ____ weeks.
❑ Pt. will be able to butt scoot within _____ weeks.
❑ Pt. will be able to sit up with/without assistance _______ within ______ weeks.

BALANCE
❑ Will increase tinetti balance score to _____/16 within _____ weeks.
❑ Pt. will be able to reach steady static/dynamic sitting/standing balance with/without assistance ______ within ______ weeks

TRANSFER
❑ Pt. will be able to transfer from _________ to _________ with/without assistance _____ within ____ weeks.

STAIR/UNEVEN SURFACE
❑ Pt. will be able to climb stair/uneven surface with/without assistance _____ steps # _______ within ________ weeks.

MUSCLE STRENGTH
❑ Pt. will be able to hold weigh _______ lb within ________ weeks.
❑ Pt. will be able to oppose flexion or extension force over _____ within ______ weeks.

PAIN
❑ Pain will decrease from ____/10 to ____ /10 within _______ weeks.

ROM
❑ Pt. will increase ROM of ________ by ______ degrees flexion/extension within _____ weeks.

SAFETY
❑ Pt. will be able to use _____ with/without assistance to _____ feet within ______ weeks.
❑ Pt. will be able to propel wheel chair _____ feet within _______ weeks.
❑ HEP will be established and initiated.

LONG TERM GOALS

Locator #22

GENERAL
❑ Gait will increase tinetti gait score to _____ / 12 within ______ weeks.
❑ Will improve gait requiring ____ to _____ from _____ to ______ within ____ weeks.

BED MOBILITY
❑ Pt. will be able to turn side (facing up) to lateral (left/right) within ____ weeks.
❑ Pt. will be able to lie back down within ______ weeks.
❑ Pt. will be able to sit up independently _______ within ______ weeks.
❑ Pt. will be able to self reposition within _______ weeks.

BALANCE
❑ Will increase tinetti balance score to _____/16 within _____ weeks.
❑ Pt. will be able to reach steady static/dynamic sitting/standing balance with/without assistance ______ within ______ weeks

TRANSFER
❑ Pt. will be able to transfer from _________ to _________ with/without assistance _______ within ____ weeks.

STAIR/UNEVEN SURFACE
❑ Pt. will be able to climb stair/uneven surface with/without assistance _____ steps # _______ within ________ weeks.

MUSCLE STRENGTH
❑ Pt. will be able to hold weigh _______ lb within ________ weeks.
❑ Pt. will be able to oppose flexion or extension force over _____ within ______ weeks.

PAIN
❑ Pain will decrease from ____/10 to ____ /10 within _______ weeks.

ROM
❑ Pt. will increase ROM of ________ by ______ degrees flexion/extension within _____ weeks.

SAFETY
❑ Pt. will be able to use _____ independently to _____ feet within ______ weeks.
❑ Pt. will be able to self propel wheel chair _____ feet within _______ weeks.
❑ Pt will be able to finalize and demonstrated to follow up HEP.

Sample 305.818.5940

ADDITIONAL SPECIFIC THERAPY GOALS

Locator #22

Note: Each modality specify location, frequency, duration, and amount.

Patient Expectation	SHORT TERM / Time Frame	LONG TERM / Time Frame

DISCHARGE PLANS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) ______

CARE COORDINATION: ❑ Physician ❑ OT ❑ SN ❑ ST ❑ MSW ❑ Aide ❑ PTA ❑ Other (specify) ______

APPROXIMATE NEXT VISIT DATE: ______
PLAN FOR NEXT VISIT ______

REHAB POTENTIAL: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Equipment needed: ______
Patient/Caregiver aware and agreeable to POC: ❑ Yes ❑ No (explain): ______

Plan developed by: ______ Date ______
Therapist Name/Signature/title

Physician signature: ______ Date ______
Please sign and return promptly

Original - Physician Copy - Clinical Record (until signed original returned)

PATIENT NAME - Last, First, Middle Initial	ID#

PHYSICAL THERAPY REVISIT NOTE

DATE OF SERVICE: ____________

❑ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

TIME IN ________ OUT ________

VITAL SIGNS: Temperature:________ Pulse:________ ❑ Regular ❑ Irregular Respirations:________ ❑ Regular ❑ Irregular
Blood Pressure: Right_____/_____ Left_____/_____ ❑ Lying ❑ Standing ❑ Sitting ❑ O2 saturation ____ % (when ordered)
Pain: ❑ None ❑ Same ❑ Improved ❑ Worse Origin________ Location(s)________
Duration________ Intensity 0- 1 0______ Other________ Relief measures________

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions
❑ Other (specify) ________

TYPE OF VISIT:
❑ Revisit
❑ Revisit and Supervisory Visit
❑ Other (specify) ________
SOC DATE: ________

TREATMENT DIAGNOSIS/PROBLEM AND EXPECTED OUTCOMES:________

PHYSICAL THERAPY INTERVENTION/INSTRUCTIONS (Mark all applicable with an "X".)

	Evaluation (B1)		Balance training/activities		Management and evaluation of care plan (B12)		Teach safe stair climbing skills
	Establish/Upgrade home exercise program		TENS		Pulmonary Physical Therapy (B6)		Teach safe/effective use of adaptive/assist
	❑ Copy given to patient		Ultrasound (B7)		Cardiopulmonary PT		device (specify)
	❑ Copy attached to chart		Electrotherapy (B8)		Pain Management		Other:
	Patient/Family education		Prosthetic training (B9)		CPM (specify)		
	Therapeutic exercise (B2)		Preprosthetic training		Functional mobility training		
	Transfer training (B3)		Fabrication of orthotic device (B10)		Teach bed mobility skills		
	Gait training (B5)		Muscle re-education (B11)		Teach hip safety precautions		

❑ Modality used ________	❑ Modality used ________	❑ Modality used ________
❑ Location ________	❑ Location ________	❑ Location ________
❑ Frequency ________	❑ Frequency ________	❑ Frequency ________
❑ Duration ________	❑ Duration ________	❑ Duration ________
❑ Intensity ________	❑ Intensity ________	❑ Intensity ________
❑ Other ________	❑ Other ________	❑ Other ________

ROM:________
STRENGTH:________
BALANCE:________
AMBULATION:________
ASSESSMENT:________

SAFETY ISSUES
❑ Obstructed pathways
❑ Home environment
❑ Stairs
❑ Unsteady gait
❑ Verbal cues required
❑ Equipment in poor condition
❑ Bathroom
❑ Commode
❑ Others:________

CARE PLAN: ❑ Reviewed/Revised with patient involvement.
If revised, specify ________
❑ Need for referral (specify)________
PLAN FOR NEXT VISIT: ________

DISCHARGE PLANS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify)________
BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify)________
CARE COORDINATION: ❑ Physician ❑ PT/PTA ❑ OT ❑ SLP ❑ MSW ❑ SN ❑ HHA ❑ Other (specify)________

SUPERVISORY VISIT (Complete if applicable)
❑ PT Assistant ❑ Aide / ❑ Present ❑ Not present
SUPERVISORY VISIT ❑ Scheduled ❑ Unscheduled
OBSERVATION OF ________
TEACHING/TRAINING OF ________
PATIENT/FAMILY FEEDBACK ON SERVICES/CARE (specify) ________
NEXT SCHEDULED SUPERVISORY VISIT ___/___/___
CARE PLAN UPDATED? ❑ No ❑ Yes (specify) ________
If PT assistant/aide not present, specify date he/she was contacted regarding updated care plan: ___/___/___

SIGNATURES/DATES

X ________ ___/___/___
Patient/Caregiver (if applicable) Date

Complete TIME OUT prior to signing below.
________ ___/___/___
Therapist (signature/title) Date

PART 1 - Clinical Record PART 2 - Therapist

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

Sample 305.818.5940

PHYSICAL THERAPY

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ____/____/____

TIME IN __________ OUT __________

OBJECTIVE DATA TESTS AND SCALES PRINTED ON OTHER PAGE.

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) __________

TYPE OF EVALUATION ☐ Initial ☐ Interim ☐ Final

SOC DATE ____/____/____

(if Initial Evaluation, complete Physical Therapy Care Plan)

PT ORDERS: ☐ Evaluation ☐ Therapeutic Exercise ☐ Transfer Training ☐ Home Program Instruction ☐ Gait Training ☐ Chest PT ☐ Ultrasound ☐ Electrotherapy ☐ Prosthetic Training ☐ Muscle Re-education ☐ Other: __________

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/ PROBLEM __________

ONSET ____/____/____

MEDICAL PRECAUTIONS: __________

MEDICAL HISTORY

☐ Hypertension ☐ Fractures
☐ Cardiac ☐ Cancer
☐ Diabetes ☐ Infection
☐ Respiratory ☐ Immunosuppressed
☐ Osteoporosis ☐ Open wound
☐ Other (specify) __________

Assistive Device:
Needs: __________
Has: __________

PRIOR/CURRENT LEVEL OF FUNCTION

Prior level of function (ADL/IADL) Specify: (ADL/IADL On Problematic Areas)

____

Current level of function (ADL/IADL) Specify: (ADL/IADL On Problematic Areas)

____

LIVING SITUATION

☐ Capable ☐ Able ☐ Willing caregiver available
☐ Limited caregiver support (ability/willingness)
☐ No caregiver available

HOME SAFETY BARRIERS:

☐ Clutter ☐ Throw rugs
☐ **Needs** grab bars ☐ Needs railings
☐ Steps (number/condition) __________
☐ Other (specify) __________

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY RECEIVED AND OUTCOMES

____

BEHAVIOR/MENTAL STATUS

☐ Alert ☐ Oriented ☐ Cooperative
☐ Conf used ☐ Memory deficits ☐ Impaired Judgement
☐ Other (specify) __________

Sample 305.818.5940

PAIN

INTENSITY: 0 1 2 3 4 5 6 7 8 9 10

LOCATION: __________

AGGRAVATING /RELIEVING FACTORS: __________

PAIN TYPE (dull, aching, etc): __________

PATTERN (Irradiation): __________

VITAL SIGNS/CURRENT STATUS

BP: ______ T.P.R.: ______ Edema: ______ Sensation: ______
Skin Condition: ______ Muscle Tone: ______ Posture: ______
Communication- ______ Vision: ______ Hearing: ______
Endurance: ______ Orthotic/ Prosthetic Devices: ______

PART 1 — Clinical Record **PART 2 — Therapist**

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

PHYSICAL THERAPY (Cont'd.)

☐ EVALUATION ☐ RE-EVALUATION

MUSCLE STRENGTH/FUNCTIONAL ROM EVAL

	AREA	STRENGTH Right	STRENGTH Left	ACTION	ROM Right	ROM Left
UPPER EXTREMITIES	Shoulder			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Elbow			Flex/Extend		
	Forearm			Sup./Pron.		
	Wrist			Flex/Extend		
	Fingers			Flex/Extend		
LOWER EXTREMITIES	Hip			Flex/Extend		
				Abd./Add.		
				Int. rot./Ext. rot.		
	Knee			Flex/Extend		
	Ankle			Plant/Dors		
	Foot			Inver/Ever		

FUNCTIONAL INDEPENDENCE/BALANCE EVAL

	TASK	ASSIST SCORE	ASSISTIVE DEVICES/COMMENTS
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Floor		
	Auto		
BALANCE	Static Sitting		
	Dynamic Sitting		
	Static Standing		
	Dynamic Standing		
W/C SKILLS	Propulsion		
	Pressure Reliefs		
	Foot Rests		
	Locks		

Sample 305.818.5940

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance.
4	Good strength - against gravity with some resistance.
3	Fair strength - against gravity - no resistance - safety compromise.
2	Poor strength - unable to move against gravity.
1	Trace strength - slight muscle contraction - no motion.
0	Zero - no active muscle contraction.

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	106% active functional motion.
4	75% active functional motion.
3	50% active functional motion.
2	25% active functional motion.
1	Less than 25%.

FUNCTIONAL INDEPENDENCE SCALE (bed mobility, transfers, W/C skills)

GRADE	DESCRIPTION
5	Physically able and does task independently.
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA)-100% patient/client effort.
2	Minimum assist (Min A)-75% patient/client effort.
1	Maximum assist (Max A)-25% - 50% patient/client effort.
0	Totally dependent-total care/support

BALANCE SCALE (sitting - standing)

GRADE	DESCRIPTION
5	Independent
4	Verbal cue (VC) only needed.
3	Stand-by assist (SBA)-100% patient/client effort.
2	Minimum assist (Min A)-75% patient/client effort.
1	Maximum assist (Max A)-25% patient/client effort.
0	Totally dependent for support.

NORMATIVE DATA FOR JOINT MOTION (ROM)

AREA	ACTION/MOVEMENT			
Shoulder	Flex	158°	Extend	55°
	Abd.	170°	Add.	50°
	Int. rot.	70°	Ext. rot.	90°
Elbow	Flex	145°	Ext.	0°
Forearm	Sup.	85°	Pron.	70°
Wrist	Flex	73°	Ext.	70°
Fingers	Flex all	90°	Ext.	0°
Hip	Flex	901-115°	Ext.	25°
	Abd.	45°	Add.	30°
	Int. rot.	45°	Ext. rot.	45°
Knee	Flex	135°	Ext.	10°
Ankle	Plant.	50°	Dors.	20°
Foot	Inv.	30°	Ever.	20°

GAIT

ASSISTANCE: ☐ Independent ☐ SBA ☐ Min. assist ☐ Mod.assist ☐ Max. assist ☐ Unable

SURFACES: ☐ Level ☐ Uneven ☐ Stairs (number/condition)__________ DISTANCE:______

WEIGHT BEARING STATUS: ☐ FWB ☐ WBAT ☐ PWB ☐ TDWB ☐ NWB

ASSISTIVE DEVICE(S): ☐ Cane ☐ Quad cane ☐ Crutches ☐ Hemi-walker ☐ Wheeled walker ☐ Walker ☐ Other (specify) __________

QUALITY/DEVIATIONS: __________

FOR RE-EVALUATION USE ONLY:

IF A PREVIOUS PLAN OF CARE WAS ESTABLISHED, THEN IT WILL:

☐ CHANGE

☐ NOT CHANGE

PATIENT INFORMATION

PATIENT'S NAME: __________ MED. RECORD #: __________

THERAPIST'S SIGNATURE/TITLE __________ DATE __/__/__ PHYSICIAN'S SIGNATURE __________ DATE __/__/__

** If no changes made to Initial Plan of care, MD signature no required.*

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

NURSING DISCHARGE SUMMARY / NOTE

PATIENT ____________

MED REC # ________ ADM DATE ________ DISCH DATE ________

DIAGNOSIS *(Primary)* ____________

DR. ____________

ADDRESS ____________

CITY, ZIP ____________ TEL ________

SERVICES RENDERED: *Frequency on ADM to Discharge*

SN ________ H H A ________

MSW ________ ☐ DIETICIAN ________

REASON FOR DISCHARGE: ____________

☐ PARTIAL - STILL RECEIVING SERVICES OF:

☐ PT ☐ ST ☐ OT ☐ HHA ________

☐ COMPLETE

CONDITION ON DISCHARGE:

☐ STABLE ☐ IMPROVED

☐ UNSTABLE ☐ DECEASED

DISPOSITION OF THE PATIENT:

☐ ABLE TO CARE FOR SELF ☐ FAMILY TO ASSIST

☐ INSTITUTIONALIZED ☐ HOMEMAKER TO ASSIST ☐ DECEASED

LAST M.D. VISIT: ________

LAB REPORTS ________

CHANGE ORDERS / NEW DIAGNOSIS:

☐ YES ☐ NO

RN CONTACTED PHYSICIAN ON DATE: ________ AND DISCHARGE IS APPROVED.

SUMMARIZE:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

☐ VERBALIZES KNOWLEDGE OF MEDICATIONS, SIDE EFFECTS, PRECAUTIONS, DIET. FLUIDS, DISEASE PROCESS, TREATMENT PROGRAM. S/S NECESSITATING MEDICAL ATTENTION.

☐ RETURN TO PREVIOUS LIFESTYLE WITH MODIFICATIONS WITHIN DISEASE LIMITATIONS.

☐ HOME FREE OF HAZARDS USING PROPER SAFETY MEASURES.

☐ PRESENTING SYMPTOMS ABSENT AND/OR CONTROLLED BY APPROPRIATE INTERVENTION.

☐ INDEPENDENCE IN SELF CARE WITHIN DISEASE LIMITATIONS.

☐ MAXIMUM POTENTIAL OF SKILLED SERVICES ATTAINED WITHIN HOME SETTING.

SKILLED OBSERVATION / ASSESSMENT ON DISCHARGE

DISCHARGED V/S ________

VITAL SIGNS RANGE:

BP ________ TO ________

AP ________ TO ________

RR ________ TO ________

TEMP ________ TO ________

GU/GI: INCONTINENT

VOIDING NORMAL

FOLEY CATHETER

BOWELS REGULATED

NOT REGULATED

OSTOMY

CATHARTIC REQUIRED

____

____

MENTAL STATUS:

☐ ALERT ☐ DISORIENTED

☐ FORGETFUL ☐ CONFUSED

ANXIOUS

DERMA:

TURGOR ☐ GOOD ☐ FAIR

☐ POOR

WOUND/DECUBITUS: ☐ HEALED

☐ NOT HEALED-PT/FAMILY DEMONSTRATES PROPER WOUND CARE

CARDIAC/CIRCULATORY:

☐ FREQUENCY OF CHEST PAIN

☐ FREE OF CHEST PAIN

☐ CONTROLLED ON MEDICATION

EDEMA: ☐ NONE ☐ TRACE

☐ MODE RATE ☐ PITTING

☐ NON-PITTING

NUTRITION:

DIET ________

☐ TUBE FEEDING ☐ TPN

APPETITE:

☐ GOOD ☐ FAIR ☐ POOR

PULMONARY:

LUNGS: ☐ CLEAR ☐ RONCHI

☐ IBS ☐ RALES ☐ WHEEZING

O2 ☐ REQUIRED

☐ NOT REQUIRED

ENDOCRINE:

DIABETES

☐ DIET CONTROLLED

☐ ORAL HYPOGLYCEMIC

☐ INSULIN DEPENDENT

EENT:

HEARING

☐ GOOD ☐ POOR

VISION

☐ GOOD ☐ POOR

PATIENT / FAMILY INSTRUCTED IN:

☐ POST CATARACT CARE

☐ INJECTION ADMINISTRATION

☐ DISEASE PROCESS

☐ S/S OF COMPLICATIONS

☐ ACTION/SIDE EFFECTS OF MEDS

☐ FOLEY CARE

☐ WOUND/DECUBITUS CARE

☐ CARE OF TERMINALLY ILL

☐ DIABETIC MANAGEMENT

☐ DIET/FLUID INTAKE

☐ OSTOMY/CONDUIT CARE

☐ SAFETY FACTORS

☐ ACTIVITY RESTRICTIONS

☐ ADMINISTRATION OF TUBE FEEDINGS

☐ ADMINISTRATION OF INHALATION RX

☐ IV THERAPY

☐ FIT. INDWELLING CATHETER CARE/PRECAUT.

☐ S/S COMPLICATIONS/INFECTION

PT/FAMILY RESPONSE AND ADHERENCE TO TEACHINGS: ☐ GOOD ☐ FAIR ☐ POOR ☐ REPETITIVE TEACHING REQUIRED

NURSING GOALS MET: ☐ YES ☐ NO .... IF NO, EXPLAIN ____________

PATIENT/FAMILY GOALS MET: ☐ YES ☐ NO ... IF NO, EXPLAIN ____________

ADDITIONAL COMMENTS AND INSTRUCTIONS: ____________

RN SIGNATURE ____________ DATE ________

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SKILLED NURSING VISIT NOTE

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS BEFORE SERVICE PROVIDED SG

SG Patient's Safety Goal

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

DATE OF VISIT ______
TIME IN ______ AM/PM OUT ______ AM/PM
TYPE OF VISIT: ☐ SN ☐ SN & Super. ☐ Super. Only ☐ Other

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Requires assistance / device to ambulate ☐ Medical restrictions ☐ Contusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Dyspnea on minimal exertion ☐ Bed / Chair bound ☐ Residual weakness ☐ Dependent upon adaptive device(s) ☐ Acute episodes of hyper/hypoglycemia yield unsafe ambulation ☐ Unable to drive ☐ Severe SOB, SOB upon exertion ☐ Other (specify) ______

MARK ALL APPLICABLE WITH AN X. CIRCLE APPROPRIATE ITEM MEDICARE ☐ MEDICAID ☐ MX ☐ OTHER ☐

VITALS

T ______ Wt ______ BS ______
Resp. ______ ☐ Reg. ☐ Irregular
Pulse: A ______ R ______
☐ Reg. ☐ Irregular

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

CARDIOVASCULAR

- Fluid Retention
- Chest Pain
- Neck Vein Distension
- Edema (specify): ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- Ascites
- Peripheral Pulses
- Arrhythmia
- Other:
- No deficit

RESPIRATORY

- Rales ☐ Ronchi ☐ Wheeze
- ☐ R. Lung ☐ L. Lung
- ☐ Cough ☐ Sputum
- ☐ Dyspnea ☐ SOB
- Orthopnea
- 02. LPM: VIA:
- No deficit ☐ Fire Prevention followed SG

DIGESTIVE

- Bowel Sound:
- ☐ Nausea ☐ Vomiting
- ☐ Anorexia ☐ NPO
- Epigastric Distress
- Difficulty Swallowing
- Abdominal Distention
- ☐ Colostomy ☐ Ileostomy
- Bowel Incontinence
- ☐ Constipation ☐ Impaction ☐ Diarrhea
- Diet:
- Fluid Intake:
- Enteral Feeding Route:
- Type: Amount:
- Via:
- Flushing:
- Appetite: ☐ Good ☐ Fair ☐ Poor
- LBM: ☐ No Deficit

GENITOURINARY

- ☐ Burning ☐ Dysuria
- ☐ Distension ☐ Retention
- ☐ Frequency ☐ Urgency ☐ Hesitancy
- Hematuria
- Bladder Incontinence
- ☐ Catheter ☐ Ileoconduit
- Suprapubic Catheter
- Foley Catheter
- Size Fr. cc.
- Last Changed:
- Irrigation cc / nsa
- Urine
- Output cc / hr.
- Color
- Consistency
- Odor
- ☐ Pain ☐ Discharge
- ☐ Cath. Leakage ☐ Dislodge
- Other
- No Deficit

SKIN

- ☐ Warm ☐ Dry ☐ No Deficit
- ☐ Cold ☐ Clammy
- ☐ Jaundice ☐ Pallor ☐ Cyanosis
- ☐ Turgor ☐ Hydration
- ☐ Rash ☐ Itching ☐ Discoloration
- ☐ Decubitus ☐ Wound ☐ Ulcer
- Chills
- Integrity
- Tube Insertion Site
- Other

ENDOCRINE

- ☐ Weakness ☐ Fatigue ☐ Tired ☐ No Deficit
- ☐ Sign/Symptoms of ☐ Polydipsia ☐ Polyphagia
- ☐ Sign/Symptoms of ☐ Hyperglycemia ☐ Hypoglycemia
- Other

MUSCULOSKELETAL

- Balance ☐ Unsteady gait ☐ Endurance
- Weakness ☐ Ambulates with Assistance
- Limited Movement ☐ Rom
- ☐ Chair Bound ☐ Bed Bound
- ☐ Contracture ☐ Paralysis
- No Deficit

NEUROSENSORY

- Syncope
- Headache
- Grasp ☐ Equal ☐ Unequal
  - Right: ______
  - Left: ______
- Movement ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- Pupil Reaction ☐ Right ☐ Left
- Hand Tremors
- Poor Hand-Eye coordination
- Poor Manual Dexterity
- Speech impairment
- Hearing Impairment
- Visual Impairment ☐ Blindness
- Tactile Sensation
- No deficit

EMOTIONAL STATUS

- Oriented ☐ T ☐ P ☐ P
- Forgetful ☐ Confused
- Disoriented ☐ T ☐ P ☐ P
- Lethargic ☐ Semi Lethargic
- Comatose
- Restless ☐ Agitated
- Anxious ☐ Depressed
- Other
- No Deficit

Denote Location / Size of Wounds / Measure Ext. Edema Bil.

Anterior Posterior

	#1	#2	#3	#4
length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

INTERVENTIONS / INSTRUCTIONS

- ☐ Skilled Observation / Assessment
- ☐ Foley Change ☐ Foley irrigation
- ☐ Wound Care ☐ Dressing Change
- ☐ Prep. / Admin. Insulin: ______
- ☐ SQ Injection: ______ Site: ______
- ☐ IM Injection: ______ Site: ______
- ☐ Diabetic Observation / Care
- ☐ Observation / Inst Med. (N or C) effects / Side Effects
- ☐ Inst. Fall Prevention ☐ Emergency Prepar. SG
- ☐ Inst. Disease Process
- ☐ Diet. Teaching
- ☐ Safety Precautions/Factors Management Conducted
- ☐ Teach Infant / Childcare
- ☐ Peg / GT Tube Site Care
- ☐ Tracheostomy Care ☐ Suctioning

TECHNIQUES USED

- ☐ Universal Precautions/ Handwashing Tech. followed
- ☐ Aseptic Tech.used / Infection Control followed SG
- ☐ Quality Control of Glucometer Performed as per Agency P & P on: ______
- ☐ Glucometer Calib. on: ______
- ☐ Soiled Dressings Double Bagged
- ☐ Sharps Discarded Inside Sharps Container

INFUSION / IV SITE: ______

- ☐ IV Tubing Change
- ☐ Cap Change ☐ Venipuncture/Lab: ______
- ☐ Central Line Dressing Change
- ☐ IV Site Dressing Change
- ☐ IV Site Change
- ☐ Infusion by ______ Pump
- ☐ Infusion Med: ______
- ☐ Infusion Rate: ______
- Comments: ______
- ☐ Infusion Well Tol. by Pt.

PAIN / FALL MANAGEMENT SG

Frequency of pain interfering with patients activity or movement:

- ☐ 0 - Patient has no pain
- ☐ 1- Pain does not interfere with activity or movement
- ☐ 2 - Less often than daily
- ☐ 3 - Daily, but not constantly
- ☐ 4 - All of the time
- ☐ Pain Management Teaching to patient / family

Intensity 0 1 2 3 4 5 6 7 8 9 10 (Low – High)

Current pain management & effectiveness: ☐ No deficit / Pain

Progress toward pain goal: ______ Patient's pain goal: ______

Primary Site(s): ______

Client is at risk for falls ☐ yes ☐ no Fall assessment conducted ☐ Yes ☐ N/A

Potential for falls: 0 1 2 3 4 5 6 7 8 9 10 ☐☐☐☐☐☐☐☐☐☐☐ Potential for falls has: Increased ☐ decreased ☐ SG

Compliant with fall prevention plan: ☐ Yes ☐ No ☐ N/A

SKILLED INTERVENTION - TEACHING - Pt. RESPONSE

______

DME/SUPPLIES: ☐ Gloves ☐ Thermometer ☐ BP cuff ☐ Glucometer ☐ Alcohol pads ☐ 4x4 ☐ Sharp container ☐ Other:

PLAN FOR NEXT VISIT:

OTHER PROGRESS TOWARDS GOALS: ☐ PT / S.O. / CG verbalized understanding of inst. given ☐ Other: ______

☐ PT / S.O. / CG able to return correct demonstration of Tech. / procedure Inst. on

DISCHARGE PLANNING DISCUSSED? Yes ☐ No ☐ N/A ☐

☐ Patient unable to perform own W/C due to: ______

☐ No S.O. or C/G able / willing for Inj. Adm. at this time ☐ Treatment well tolerated by Patient

☐ No S.O. or C/G able / willing for wound care at this time. ☐ Verification of Procedure Performed SG

CARE PLAN: ☐ Reviewed / Revised with patient / client involvement. ☐ Outcome achieved

☐ PRN Order Obtained: ______

☐ **Verification of Medication Performed Prior to Admin.** SG

MEDICATION STATUS ☐ No Change ☐ Order Obtained: ______

SUPPLIES USED: ______

CARE COORDINATION: Physician ☐ PT ☐ OT ☐ ST ☐ MSW ☐ SN ☐ C M ☐ HHA ☐

☐ Other: ______

NURSE SIGNATURE / PRINT NAME **RN / LPN** **DATE**

Signature / Date -Complete TIME OUT (above) prior to signing below (circle title) ___/___/___

Sample 305.818.5940

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

PSYCHIATRIC NURSE PROGRESS NOTE

PATIENT'S NAME LAST NAME	FIRST NAME	PATIENT'S NUMBER	DATE MO, DAY YR.			EMPLOYEE NUMBER	INITIALS

HOMEBOUND DUE TO: ______

NURSING VISIT CODE
RV - ROUTINE VISIT
EV - EMERGENCY VISIT

SKILLED NURSING SERVICES

OBSERVATIONS/MONITORING

VITAL SIGNS: BP ____ AP ____ REG ____ IRREG ____
TEMP ____ RESPIRATIONS ____
LUNGS: CTA ____ RALES ____ ↓ BS ____

MENTAL STATUS: IMPROVED ____ SAME ____ REGRESSED ____
☐ ALERT ☐ CONFUSED ☐ DISORIENTED
☐ HALLUCINATIONS/DELUSIONS: PRESENT ____ ABSENT ____
☐ SUICIDAL TENDENCIES: PRESENT ____ ABSENT ____
☐ EXTRAPYRAMIDAL SX- PRESENT ____ ABSENT ____
☐ ORIENTED: TIME ____ PLACE ____ PERSON ____
☐ INSIGHT PT/FAMILY: GOOD ____ FAIR ____ POOR ____

MOOD/AFFECT: IMPROVED ____ SAME ____ REGRESSED ____
☐ FLAT ☐ DEPRESSED ☐ COMBATIVE
☐ AGITATED ☐ ANXIOUS ☐ NEGATIVE

COMMUNICATION: IMPROVED ____ SAME ____ REGRESSED ____
SOCIALIZATION: ______
SOMATIZATION: ______
VENTILATES FEELINGS: GOOD ____ FAIR ____ POOR ____

RAPPORT: ______
PATIENT with FAMILY: IMPROVED ____ SAME ____ REGRESSED ____
FAMILY with PATIENT: IMPROVED ____ SAME ____ REGRESSED ____
PATIENT with RN: IMPROVED ____ SAME ____ REGRESSED ____
FAMILY with RN: IMPROVED ____ SAME ____ REGRESSED ____

NUTRITION STATUS:
APPETITE: IMPROVED ____ SAME ____ DECREASED ____
FLUID INTAKE: IMPROVED ____ SAME ____ DECREASED ____

G.I. BOWEL FUNCTIONS: REGULATED ____ IRREGULAR ____
CATHARTIC REQUIRED: YES ____ NO ____

ADL LEVEL: IMPROVED __ SAME __ REGRESSED __
DRESSING: IMPROVED __ SAME __ REGRESSED __
MOTIVATION: IMPROVED __ SAME __ REGRESSED __
PERSONAL HYGIENE: IMPROVED __ SAME __ REGRESSED __
SLEEPING HABITS: IMPROVED __ SAME __ INSOMNIA __

PATIENT/FAMILY TEACHINGS:

☐ MEDICATION REGIME
☐ ACTION/SIDE EFFECTS OF: ______
☐ S/S DISEASE PROCESS OF: ______
☐ S/S OF COMPLICATIONS OF: ______
☐ EXTRAPYRAMIDAL SYMPTOMS
☐ SAFETY MEASURES
☐ RELAXATION TECHNIQUES

NUTRITION

☐ DIET ______
☐ PROPER FLUID INTAKE

THERAPY PROVIDED

☐ SUPPORTIVE
☐ REALITY

AIDE SUPERVISORY VISIT

	YES	NO
PATIENT SATISFIED WITH CARE	☐	☐
AIDE FOLLOWING CARE PLAN	☐	☐
CARE PLAN UPDATED	☐	☐

AIDE NEEDED ____ TIMES PER WEEK

SPECIFIC MEDICAL TREATMENTS/TEACHINGS

______

ASSESSMENT OF PROBLEMS AND RESPONSES:

______

PLAN:

______

PHYSICIAN COMMUNICATION:

ADDITIONAL/CHANGE ORDERS:

DISCHARGE PLANNING:

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WHITE: CHART YELLOW: COPY

______
SIGNATURE OF R.N.

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

PSYCHIATRIC NURSING ASSESSMENT

PT. NAME ____________________ PT. # __________ HI # __________

CHECK (☑) BOX OR CIRCLE NUMBER FOR MOST APPROPRIATE ANSWER.
IF "NORMAL" IS CHECKED, GO TO NEXT SECTION.
IF NOT "NORMAL", RATE PERTINENT ITEMS ONLY.

1= MILD * 2 =MODERATE * 3 = SEVERE (Marked)

GENERAL APPEARANCE

— NORMAL ☐

FACIAL EXPRESSIONS:

- SAD 1 2 3
- EXPRESSIONLESS 1 2 3
- HOSTILE 1 2 3
- WORRIED 1 2 3
- AVOIDS GAZE 1 2 3

DRESS:

- METICULOUS 1 2 3
- CLOTHING, HYGIENE POOR 1 2 3
- ECCENTRIC 1 2 3
- SEDUCTIVE 1 2 3
- EXPOSED 1 2 3

MOTOR ACTIVITY

— NORMAL ☐

- INCREASED AMOUNT 1 2 3
- DECREASED AMOUNT 1 2 3
- AGITATION 1 2 3
- TICS 1 2 3
- TREMOR 1 2 3
- PECULIAR POSTURING 1 2 3
- UNUSUAL GAIT 1 2 3
- REPETITIVE ACTS 1 2 3

SPEECH

— NORMAL ☐

- EXCESSIVE AMOUNT 1 2 3
- REDUCED AMOUNT 1 2 3
- SPEECH 1 2 3
- SLOWED 1 2 3
- LOUD 1 2 3
- SOFT 1 2 3
- MUTE 1 2 3
- SLURRED 1 2 3
- STUTTERING 1 2 3

INTERVIEW BEHAVIOR

— NORMAL ☐

- ANGRY OUTBURSTS 1 2 3
- IRRITABLE 1 2 3
- IMPULSIVE 1 2 3
- HOSTILE 1 2 3
- SILLY 1 2 3
- SENSITIVE 1 2 3
- APATHETIC 1 2 3
- WITHDRAWN 1 2 3
- EVASIVE 1 2 3
- PASSIVE 1 2 3
- AGGRESSIVE 1 2 3
- NAIVE 1 2 3
- OVERLY DRAMATIC 1 2 3
- MANIPULATIVE 1 2 3
- DEPENDENT 1 2 3
- UNCOOPERATIVE 1 2 3
- DEMANDING 1 2 3
- NEGATIVISTIC 1 2 3
- CALLOUS 1 2 3
- MOOD SWINGS 1 2 3

FLOW OF THOUGHT

— NORMAL ☐

- BLOCKING 1 2 3
- CIRCUMSTANTIAL 1 2 3
- TANGENTIAL 1 2 3
- PERSEVERATION 1 2 3
- FLIGHT OF IDEAS 1 2 3
- LOOSE ASSOCIATION 1 2 3
- INDECISIVE 1 2 3

MOOD AND AFFECT

— NORMAL ☐

- ANXIOUS 1 2 3
- INAPPROPRIATE AFFECT 1 2 3
- FLAT AFFECT 1 2 3
- ELEVATED MOOD 1 2 3
- DEPRESSED MOOD 1 2 3
- LABILE MOOD 1 2 3

CONTENT OF THOUGHT

— NORMAL ☐

- SUICIDAL THOUGHTS 1 2 3
- SUICIDAL PLANS 1 2 3
- ASSAULTIVE IDEAS 1 2 3
- HOMICIDAL THOUGHTS 1 2 3
- HOMICIDAL PLANS 1 2 3
- ANTISOCIAL ATTITUDES 1 2 3
- SUSPICIOUSNESS 1 2 3
- POVERTY OF CONTENT 1 2 3
- PHOBIAS 1 2 3
- OBSESSIONS 1 2 3
- COMPULSIONS 1 2 3
- FEELINGS OF UNREALITY 1 2 3
- FEELS PERSECUTED 1 2 3
- THOUGHTS OF RUNNING AWAY.. 1 2 3
- SOMATIC COMPLAINTS 1 2 3
- IDEAS OF GUILT 1 2 3
- IDEAS OF HOPELESSNESS 1 2 3
- IDEAS OF WORTHLESSNESS ... 1 2 3
- EXCESSIVE RELIGIOSITY 1 2 3
- SEXUAL PREOCCUPATION 1 2 3
- BLAMES OTHERS 1 2 3

ILLUSIONS:

- PRESENT 1 2 3

HALLUCINATIONS:

- AUDITORY 1 2 3
- VISUAL 1 2 3
- OTHER 1 2 3

DELUSIONS:

- OF PERSECUTION 1 2 3
- OF GRANDEUR 1 2 3
- OF REFERENCE 1 2 3
- OF INFLUENCE 1 2 3
- SOMATIC 1 2 3
- OTHER 1 2 3
- ARE SYSTEMATIZED 1 2 3

SENSORIUM

— NORMAL ☐

ORIENTATION IMPAIRED

- TIME 1 2 3
- PLACE 1 2 3
- PERSON 1 2 3

MEMORY

- CLOUDING OF CONSCIOUSNESS .1 2 3
- INABILITY TO CONCENTRATE .. 1 2 3
- AMNESIA 1 2 3
- POOR RECENT MEMORY 1 2 3
- POOR REMOTE MEMORY 1 2 3
- CONFABULATION 1 2 3

INTELLECT

— NORMAL ☐

- ABOVE NORMAL 1 2 3
- BELOW NORMAL 1 2 3
- PAUCITY OF KNOWLEDGE 1 2 3
- VOCABULARY POOR 1 2 3
- SERIAL SEVENS DONE POORLY. 1 2 3
- POOR ABSTRACTION 1 2 3

INSIGHT AND JUDGMENT

— NORMAL ☐

- POOR INSIGHT 1 2 3
- POOR JUDGMENT 1 2 3
- UNREALISTIC REGARDING DEGREE OF ILLNESS 1 2 3
- DOESN'T KNOW WHY HE IS HERE 1 2 3
- UNMOTIVATED FOR TREATMENT 1 2 3
- UNREALISTIC REGARDING GOALS 1 2 3

ADDITIONAL COMMENTS: (Write in Delusions and Hallucinations)

PSYCHIATRICALLY HOMEBOUND:
A. Refuses to leave his home ______ ______
B. Not safe to leave his home unattended

RN SIGNATURE ____________________ DATE __________

Sample 305.818.5940

SPEECH THERAPY EVALUATION

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ____/____/____
TIME IN ________ OUT ________

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Residual weakness
☐ Requires assistance to ambulate ☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion
☐ Dependent upon adaptive device(s) ☐ Medical restrictions
☐ Other (specify) ________

TYPE OF EVALUATION
☐ Initial ☐ Interim ☐ Final
SOC DATE ____/____/____
(If Initial Evaluation, complete Speech Therapy Care Plan)

ORDERS FOR EVALUATION ONLY? ☐ Yes ☐ No If no, orders are ________

PERTINENT BACKGROUND INFORMATION

TREATMENT DIAGNOSIS/ PROBLEM ________

ONSET ____/____/____

MEDICAL PRECAUTIONS: ________

MEDICAL HISTORY

☐ Hypertension ☐ Fractures
☐ Cardiac ☐ Cancer
☐ Diabetes ☐ Infection
☐ Respiratory ☐ Immunosuppressed
☐ Osteoporosis ☐ Open wound
☐ Other (specify) ________

Assistive Device:
Needs: ________
Has: ________

LIVING SITUATION

☐ Capable ☐ Able ☐ Willing caregiver available
☐ Limited caregiver support (ability/willingness)
☐ No caregiver available

HOME SAFETY BARRIERS:
☐ Clutter ☐ Throw rugs
☐ **Needs** grab bars ☐ Needs railings
☐ Steps (number/condition) ________
☐ Other (specify) ________

BEHAVIOR/MENTAL STATUS

☐ Alert ☐ Oriented ☐ Cooperative
☐ Conf used ☐ Memory deficits ☐ Impaired Judgement
☐ Other (specify) ________

PAIN

INTENSITY: 0 1 2 3 4 5 6 7 8 9 10
LOCATION: ________
AGGRAVATING /RELIEVING FACTORS: ________
PAIN TYPE (dull, aching, etc): ________
PATTERN (Irradiation): ________

PRIOR/CURRENT LEVEL OF FUNCTION

Prior level of function Specify Problematic Areas
____

Current level of function Specify Problematic Areas
____

PERTINENT MEDICAL/SOCIAL HISTORY AND/OR PREVIOUS THERAPY RECEIVED AND OUTCOMES

____

SAFE SWALLOWING EVALUATION: ☐ No ☐ Yes, specify date and M.D. ________

VIDEO FLUOROSCOPY?: ☐ No ☐ Yes, specify date and M.D. ________

CURRENT DIET TEXTURE: ________

LIQUIDS: ☐ Thin ☐ Thickened (Specify): ________ Other (Specify): ________

THERAPIST SIGNATURE/TITLE ________ DATE ____/____/____

PART 1 - Clinical Record PART 2 - Therapist

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

Sample 305.318.5940

SPEECH THERAPY EVALUATION

☐ EVALUATION ☐ RE-EVALUATION

DATE OF SERVICE ____/____/____
TIME IN __________ OUT __________

COGNITIVE STATUS/COMPREHENSION SPEECH/LANGUAGE EVALUATION SENSORY/PERCEPTUAL

4- WFL (within functional limits) 3 - Mild impairment 2 - Moderate impairment 1 - Severe impairment 0- Unable to do/did not test

	FUNCTION EVALUATED	SCORE	COMMENTS		FUNCTION EVALUATED	SCORE	COMMENTS
COGNITION	Orientation (Person/Place/Time)			VERBAL EXPRESSION	Augmentative methods		
	Attention span				Naming		
	Short-term memory				Appropriate Yes / No		
	Long-term memory				Complex sentences		
	Judgment				Conversation		
	Problem solving			AUDITORY COMPREHENSION	Word discrimination		
	Organization				1 step directions		
	Other:				2 step directions		
					Complex directions		
SPEECH/VOICE	Oral/facial exam				Conversation		
	Articulation				Speech reading		
	Prosody			READING	Letters/Numbers		
	Voice/Respiration				Words		
	Speech intelligibility				Simple sentences		
	Other:				Complex sentences		
					Paragraph		
SWALLOWING	Chewing ability			WRITING	Letters/Numbers		
	Oral stage management				Words		
	Pharyngeal stage management				Sentences		
	Reflex time				Spelling		
	Other:				Formulation		
					Simple addition/subtraction		

REFERRAL FOR: ❑ Vision ❑ Hearing ❑ Swallowing ❑ Other (Specify) ____________

CLINICAL FINDING

ORAL PERIPHERAL EXAM	ORAL MOTOR EXAM	
UPS	UPS ABDUCTED	ADDUCTED
MANDIBLE	TONGUE ELEVATION	PROTRUSION
MAXILLA	TONGUE RETRACTION	LATERALIZATION
TEETH	VELUM ELEVATION	
OCCLUSION	P-T-K FORWARD	BACKWARD
PALATE	PHONEME CONTROL	
UVULA	Do sensory/perceptual affect safety? ❑ Yes ❑ No If yes, recommendations:	
PHARYNX	COMMENTS:	

COMMUNICATION DEVICES

VISUAL TRACKING:
R/L DISCRIMINATION:
MOTOR PLANNING PRAXIS:

FOR RE-EVALUATION USE ONLY: IF A PREVIOUS PLAN OF CARE WAS ESTABLISHED, THEM IT WILL: ❑ CHANGE ❑ NOT CHANGE

TEST	SCORE	COMMENTS	TEST	SCORE	COMMENTS

PATIENT'S NAME: ______________________ MED. RECORD #: ____________

THERAPIST'S SIGNATURE/TITLE ____________________ DATE ___/___/___ PHYSICIAN'S SIGNATURE ____________________ DATE ___/___/___

** If no changes made to Initial Plan of care, MD signature no required.*

Sample 305.815.5940

SPEECH THERAPY REVISIT NOTE

DATE OF SERVICE ____/____

TIME IN ______ OUT ______

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness
❑ Requires assistance to ambulate ❑ Confusion, unable to go out of home alone
❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ☐ Medical restrictions
❑ Other (specify) ______

TYPE OF VISIT
❑ Revisit
❑ Revisit and Supervisory Visit
❑ Other (specify) ______
SOC DATE ____/____/____

TREATMENT DIAGNOSIS/PROBLEM ______

EXPECTED TREATMENT OUTCOME(S) ______

SPEECH THERAPY INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X")

	Evaluation (C1)		Aural rehabilitation (C6)		Pain Management
	Establish rehab. program		Non-oral communication (C8)		Speech dysphagia instruction program
	Establish home maintenance program ❑ Copy given to patient ❑ Copy attached to chart		Alaryngeal speech skills		Care of voice prosthesis including removal, cleaning, site maintenance
			Language processing		
			Food texture recommendations		Teach/Develop communication system
	Patient/Family education		Safe swallowing evaluation		Trach. instruction and care
	Voice disorders (C2)		Therapy to increase articulation, proficiency, verbal expression		Retraining of cognitive, feeding, and perceptual skills
	Speech articulation disorders (C3)				Teach safe/effective use of communication device (specify): device
	Dysphagia treatments (C4)		Lip, tongue, facial exercises to improve swallowing/vocal skills		
	Language disorders (C5)				Other:

Note Each Modality, specify frequency, duration, amount: ______

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES: ______

EVALUATION AND PATIENT/CAREGIVER RESPONSE: ______

Sample 305.818.5940

CARE PLAN: ❑ Reviewed/Revised with patient involvement.
If revised, specify ______

❑ Outcome/instruction achieved (describe) ______

❑ PRN order obtained
APPROXIMATE NEXT VISIT DATE: ____/____/____
PLAN FOR NEXT VISIT ______

DISCHARGE DISCUSSED WITH: ❑ Patient/Family
❑ Care Manager ❑ Physician ❑ Other (specify) ______
BILLABLE SUPPLIES RECORDED? ❑ N/A ❑ Yes (specify) ______

CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ ST ❑ SS
❑ SN ❑ Other (specify) ______

SUPERVISORY VISIT (Complete if applicable)

❑ ST Assistant ❑ Aide / ❑ Present ❑ Not present
SUPERVISORY VISIT ❑ Scheduled ❑ Unscheduled
OBSERVATION OF ______

TEACHING /TRAINING OF ______

PATIENT/FAMILY FEEDBACK ON SERVICES/CARE
(specify) ______

NEXT SCHEDULED SUPERVISORY VISIT ____/____/____
CARE PLAN UPDATED? ❑ No ❑ Yes (specify) ______

If ST assistant/aide **not present,** specify date he/she was contacted regarding updated care plan: ____/____/____

SIGNATURES/DATES

X ______ ____/____/____
Patient/Caregiver (if applicable) *Date*

Complete TIME OUT (above) prior to signing below.
______ ____/____/____
Therapist (signature/title) *Date*

PART 1 - Clinical Record PART 2 - Therapist

PATIENT NAME - Last, First, Middle Initial	ID#

SPEECH THERAPY CARE PLAN

☐ INITIAL
☐ UPDATED

SOC DATE ____/____/____

TREATMENT DIAGNOSIS/PROBLEM ________________________________

ONSET: ____/____/____

ANALYSIS OF EVALUATION/TEST SCORES ________________________________

PLAN OF CARE SPEECH THERAPY: INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X".)

	Evaluation (C1)		Aural rehabilitation (C6)		Pain Management
	Establish rehab. program		Non-oral communication (C8)		Speech dysphagia instruction program
	Establish home maintenance program		Alaryngeal speech skills		Care of voice prosthesis including
	❑ Copy given to patient		Language processing		removal, cleaning, site maintenance
	❑ Copy attached to chart		Food texture recommendations		Teach/Develop communication system
	Patient/Family education		Safe swallowing evaluation		Trach. instruction and care
	Voice disorders (C2)		Therapy to increase articulation,		Retraining of cognitive, feeding, and perceptual skills
	Speech articulation disorders (C3)		proficiency, verbal expression		Teach safe/effective use of communication device (specify): device
	Dysphagia treatments (C4)		Lip, tongue, facial exercises to		
	Language disorders (C5)		improve swallowing/vocal skills		Other:

Note Each Modality, specify frequency, duration, amount: ________________________________

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES: ________________________________

EVALUATION AND PATIENT/CAREGIVER RESPONSE: ________________________________

ADDITIONAL SPECIFIC SPEECH THERAPY GOALS **Locator # 22**

Note: Each Modality, specify frequency, duration, amount

PATIENT EXPECTATION	SHORT TERM Time Frame	LONG TERM Time Frame

Sample
305.818.5940

FREQUENCY AND DURATION ________________ REHAB POTENTIAL ❑ Good ❑ Fair ❑ Poor

EQUIPMENT RECOMMENDATIONS ________________________________

SAFETY ISSUES/INSTRUCTION/EDUCATION ________________________________

PATIENT/CAREGIVER RESPONSE TO PLAN OF CARE ________________________________

DISCHARGE DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) ____________

CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ STA ❑ SS ❑ SN ❑ Other (specify) ____________

APPROXIMATE NEXT VISIT DATE ____/____/____

PLAN FOR NEXT VISIT ________________________________

DISCHARGE PLAN: ❑ When goals met ❑ Other (specify): ________________________________

PLAN DEVELOPED BY: ________________ ________________ ____/____/____

Therapist Name Signature & Title Date

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature/title)	COMMENTS

PART 1 - Clinical Record PART 2 - Therapist

PATIENT NAME - Last, First, Middle Initial	ID#

Multidisciplinary Team Conference /Progress Summary

Pt. Name: ______________________________ S.O.C.-________________ MR #:__________

Diagnoses:______________________________ Doctor's Name:________________________

______________________________ Address:______________________________

______________________________ ______________________________

Disciplines and individuals participating:

Pt. Care Sup:______________________________ PT/PTA ______________________________

Doctor:______________________________ OT/OTA ______________________________

Nurse:______________________________ ST ______________________________

Nurse:______________________________ MSW ______________________________

Aide (s):______________________________ Other:______________________________

Sample 305.818.5940

Problems addressed/Summary of Condition:______________________________

____

____

____

____

____

____

Plan of Action/Goals established:______________________________

____

____

____

____

____

Careplan: ___ reviewed ___ updated

Patient Disposition: ___ Continue same P.O.C.

___ Recertify

___ Discharge

Change in Visit Frequencies:

SN ________________ PT ________________

Aide ________________ ST ________________

MSW________________ OT ________________

Progress towards goals: (explain:) ______________________________

____

____

____

______________________________ ______________________________

Patient Care Sup.signature Date of Conference

White (Chart) **Yellow (PC Supervisor)**

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

THERAPY DISCHARGE SUMMARY

PATIENT LAST NAME ____________ FIRST NAME ____________ PATIENT # ____________

TYPE OF DISCHARGE: ☐ COMPLETE ☐ PARTIAL - STILL RECEIVING SERVICES OF: ☐ PT ☐ ST ☐ OT ☐ HHA ☐ SN

ADM DATE ____________ **DISCH DATE** ____________ DR ____________

DIAGNOSIS (PRIMARY) ____________ ADDRESS ____________

CITY, ST ____________ ZIP ____________

VISITS RENDERED BY: ______ RN ______ HHA ______ PT ______ OT ______ ST ______ Msw

REASON FOR DISCHARGE:
- ☐ GOALS MET
- ☐ HOSPITALIZATION
- ☐ SKILLED NURSING FACILITY
- ☐ TRANSFER TO ANOTHER AGENCY
- ☐ MOVED OUT OF AREA
- ☐ PATIENT EXPIRED
- ☐ CARE REFUSED
- ☐ SKILLED CARE NO LONGER NEEDED
- ☐ OTHER

DISPOSITION ☐ SELF CARE ☐ NH ☐ ACLF ☐ FAMILY CARE ☐ OTHER

CONDITION ☐ IMPROVED ☐ STABLE ☐ UNSTABLE ☐ DECEASED ☐ REGRESSED

DEPENDENCY ☐ DEPENDENT ☐ INDEPENDENT ☐ REQUIRES SUPERVISION/ASSIST

EXERCISES ☐ PASSIVE ☐ ACTIVE ☐ ACTIVE ASSISTIVE ☐ RESISTIVE

PERFORMED WITH: ☐ R.U.E. ☐ R.L.E. ☐ L.U.E. ☐ L.L.E. ☐ TRUNK ☐ NECK

TRANSFER ACTIVITIES: ☐ HOYER LIFT ☐ CRUTCHES ☐ WALKER ☐ W/C ☐ CANE ☐ QUAD CANE ☐ OTHER ____________

GAIT TRAINING: ☐ N.W.B. ☐ P.W.B. ☐ F.W.B. ☐ EVEN SURFACES ☐ STAIRS ☐ UNEVEN SURFACES

ASSISTANCE REQUIRED: ☐ MAXIMUM ☐ MINIMUM ☐ MODERATE ☐ GUARDING ☐ OTHER ____________

DISTANCE AMBULATED: ☐ 20 ft. ☐ 40 ft. ☐ 60 ft. ☐ 80 ft. ☐ 100 ft. ☐ 120 ft.

INSTRUCTED ON HOME PROGRAM: ☐ PATIENT ☐ SIGNIFICANT OTHER ☐ FAMILY

NARRATIVE: ____________

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

Physical Therapy

- ______ PATIENT HAS ACHIEVED ANTICIPATED GOALS
- ______ PATIENT IS SAFELY INDEPENDENT WITHIN DISEASE LIMITATIONS
- ______ ABSENCE OF PAIN
- ______ FREE OF CONTRACTURES
- ______ RANGE OF MOTION OF ALL JOINTS IS WITHIN NORMAL RANGE
- ______ DEMONSTRATES RANGE OF MOTION EXERCISES
- ______ DEMONSTRATES MUSCLE STRENGTHENING EXERCISES
- ______ DEMONSTRATES TURNING AND POSITIONING SCHEDULE
- ______ AMBULATES SAFELY WITH ASSISTIVE DEVICE
- ______ AMBULATES SAFELY WITHOUT ASSISTIVE DEVICE
- ______ DEMONSTRATES TRANSFER TECHNIQUE AND USE OF SPECIAL DEVICES
- ______ DEMONSTRATES ABILITY TO DO SPECIAL TREATMENTS
- ______ HEALED INCISION
- ______ DEMONSTRATES STUMP WRAPPING AND HYGIENE
- ______ DEMONSTRATES TECHNIQUE TO CARE FOR AND PROTECT FUNCTIONING EXTREMITY
- ______ DESCRIBES PHANTOM LIMB SENSATION
- ______ PATIENT DEMONSTRATES STABILIZATION OF AMBULATION

Speech Therapy

- ______ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
- ______ PATIENT HAS ATTAINED MAXIMUM BENEFIT FROM THERAPEUTIC PROGRAM
- ______ VERBAL AND SENTENCE FORMULATION AND COMPREHENSION IMPROVED TO MAXIMUM ATTAINMENT WITHIN DISEASE LIMITATIONS

Occupational Therapy

- ______ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
- ______ DEMONSTRATES KNOWLEDGE OF OPERATION & CARE OF ADAPTIVE EQUIPMENT
- ______ DEMONSTRATES ENERGY CONSERVATION/WORK SIMPLIFICATION TECHNIQUES
- ______ DEMONSTRATIONS COMPENSATORY & SAFETY TECHNIQUES

PATIENT/S.O. RESPONSE AND ADHERENCE TO TEACHING: ☐ GOOD ☐ FAIR ☐ POOR

THERAPY GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN ____________

PATIENT/S.O.GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN ____________

COMMENTS: ____________

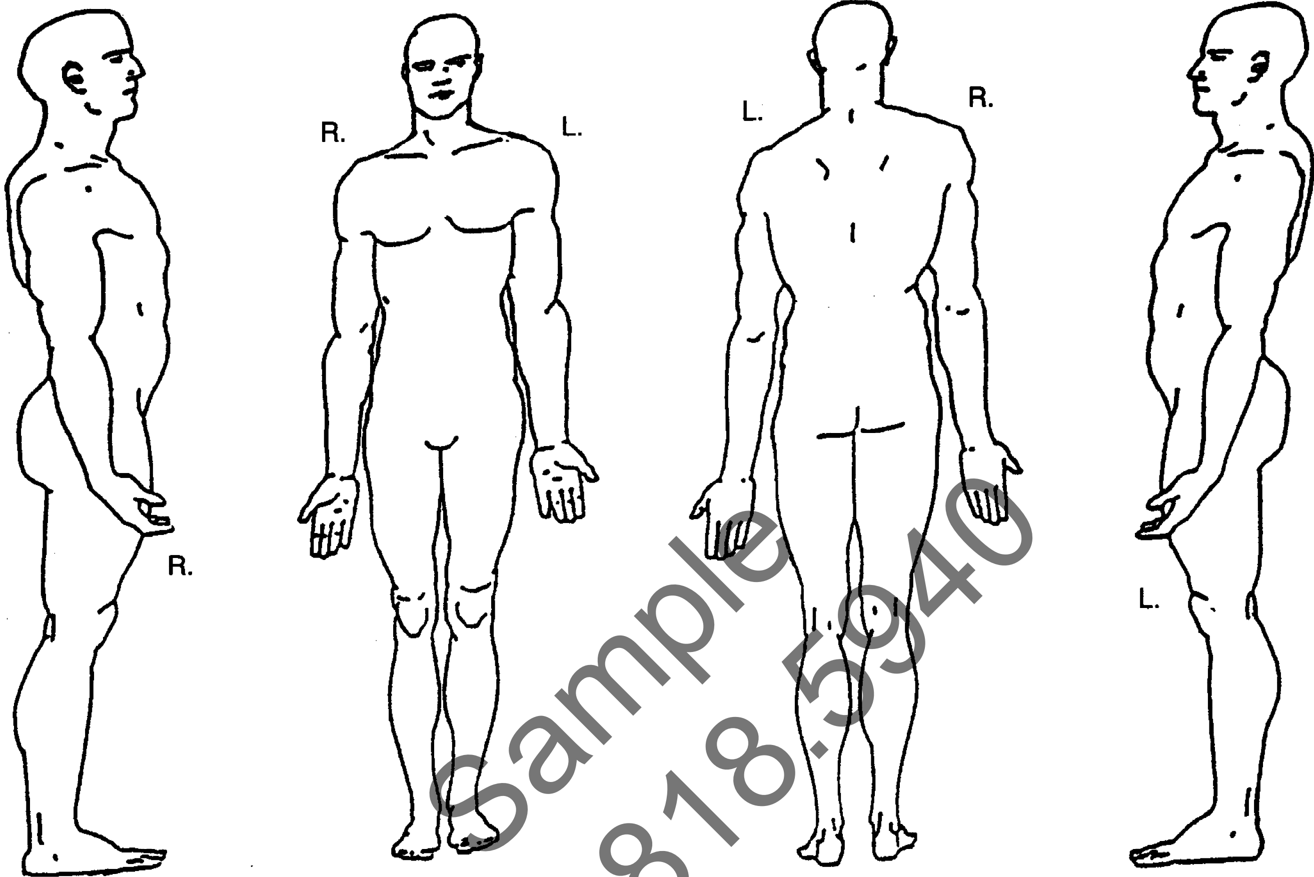
☐ PATIENTS/So. INSTRUCTED ON IMPORTANCE OF ADHERENCE OF EXERCISE PROGRAM, M.D. FOLLOW-UP AND NOTIFY M.D. IF COMPLICATIONS OCCUR. ☐ M.D. NOTIFIED OF DISCHARGE

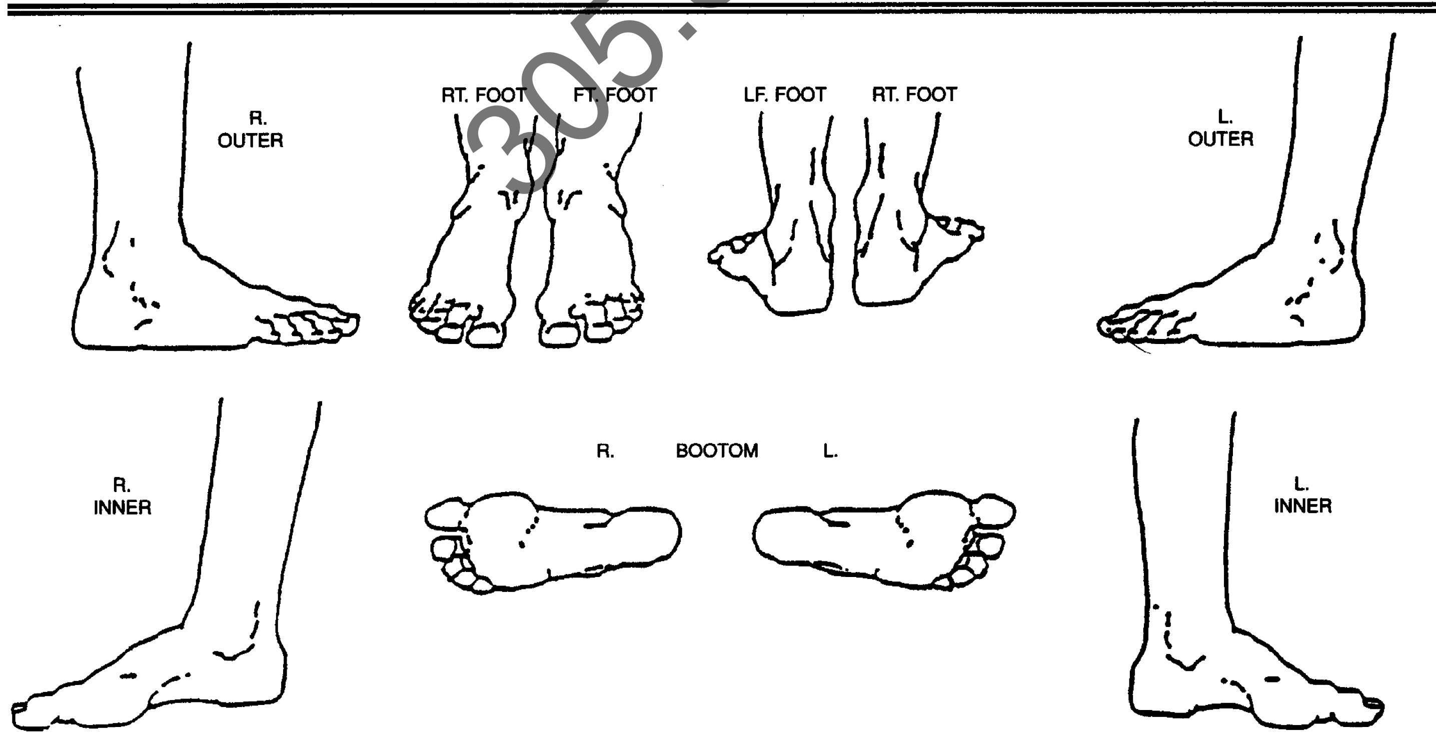
THERAPIST SIGNATURE ____________ DATE ____________

Sample 305.818.5940

PATIENT NAME (Last, First)	CR#	DATE	EMPLOYEE INITIALS / #

BODY CHARTS





Sample
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____

Nurse Signature

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

WOUND RECORD

Addendum to Nurse's Note

PATIENT: ______________________________ CR#: ______________

Week of: ______________ to ______________

Date	CURRENT WOUND CARE *(changes require MOD order)*

WOUND DESCRIPTION, measurements are: cm or mm" *(circle one)*

Location	L	W	D	U or T	Appearance	Drainage: Amt. Color/Odor	Surrounding Skin
#1							
#2							
#3							
#4							

KEY: L - length *W - width* *D - depth* *U - undermining* *T - tunnelling*

Date	Change in description of wound and additional pertinent information: (sensation, physician intervention sutures, deterioration, location of undermining and/or tunneling, date of debridement, culture, etc.)

Signature: ______________________________ Date: ____________

Sample 305.818.5940

PATIENT DISCHARGE. NOTIFICATION/INSTRUCTIONS
ALTA DEL PACIENTE. NOTIFICACION/INTRUCCIONES

Discharge Date/*Fecha de Alta del Paciente*

Patient Name/*Nombre de el(la) Paciente*

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

Patient Record Number/*Número de Record del Paciente*

Dear Patient/*Estimado Paciente:*

It has been our pleasure to assist you during your recovery period from your recent illness, in accordance with your private physician's plan of treatment and in compliance with Medicare/Medicaid guidelines, you are being discharged from all home health services.
Ha sido un placer asistirlo durante su periodo de recuperación de su reciente enfermedad. De acuerdo con el plan de tratamiento de su médico y en cumplimiento de las regulaciones de Medicare/Medicaid, Ud. está siendo dado de alta de sus servicios de cuidado a la casa.

l.-Continue to follow any Diet instructions you received/*Continúe las Instrucciones de Dieta Recibidas.*
Current Diet/*Dieta Corriente* ______

2.-Take Only Medications Prescribed by Your Doctor, Discard all Out-Dated Medications/*Tome Solamente Medicamentos Recetados por su Doctor, Deseche Todos los Medicamentos Expirados.*
Current Medications Include*lMedicamentosActuales lncluyen* ______

3.-Continue with the Following Treatments/*Continue con los Siguientes Tratamientos:*
Current Treatments Include/*Tratamientos Actuales Incluyen* ______

4.-Continue with the Following Activities/*Continue con las Siguientes Actividades:*
Current Activities Include/*Actividades Actuales Incluyen* ______

Special Precautions/*Precauciones Especiales* ______

Psychosocial Need Follow/*Necesidades Psycosociales a Seguir* ______

Community Resource to Contact-Referrals Made/*Recursos de la Comunidad para Contactar o Referir* ______

Sample 305.818.5940

Keep Doctor's Name and Phone Number, and Your Address Clearly Printed Next to Your Phone or On Your Refrigerator. Keep Name and Phone Number of Friend or Relative to Be Contacted in Case of Emergency, Next to Your Phone or On Your Refrigerator.
Mantenga Nombre y Teléfono de Su Médico, así como su dirección, claramente escritos Cerca de Su Teléfono o Refrigerador. Mantenga Nombre y Teléfono de un Amigo o Familiar que Pueda Ser Contactado en Caso de Emergencia

Physician Name/*Nombre del Médico* ______
Phone Number/*Número de Teléfono* ______
Next Physician Appointment/*Próxima Cita* ______
Instructions given to/*Instrucciones dadas a* ______
Relationship to Patient/*Relación con el Paciente* ______

Patient signature / *Firma del Paciente* ______ Date/*Fecha* ______

Witness (Agency's Representative)/*Testigo(Representante de la Agencia.)* ______ Date/*Fecha* ______

FOR EMERGENCY CALL 911 - *EN CASO DE EMERGENCIA LLAME AL 911*

CONSENT ASSISTANCE WITH SELF-ADMINISTERED MEDICATIONS BY NON-LICENSED PERSONNEL

CONSENTIMIENTO PARA RECIBIR AYUDA CON LA ADMINISTRACION PERSONAL DE MEDICAMENTOS POR UN EMPLEADO NO LICENSIADO

I ______________________________ [patient, or patient's surrogate, or guardian, or attorney in fact's name], herein referred to as "the patient", hereby state that I have been informed of the following facts: *Yo he sido informado de:*

1. That the patient may be receiving assistance with self-administration of medication from an unlicensed person; i.e. home health aides. *Puede el pciente recibir ayuda de un personal no licenciado en la administración personal de medicamentos (Ejemplo Auxiliar de Enfermera)*

2. That the patient's home health aides are: *Las auxiliares de Enfermeras son:*

· **Not currently licensed to practice nursing or medicine**; *(No tienen licencia para practicar enfermería o medicina)*

· **Employees of our agency; and** *(Empleados de nuestra Agencia)*

· **Trained with respect to assisting with the self-administration of medication as provided in rule promulgated by the Agency for Health Care Administration.** *Estan entrenadas para ayudarlo con su propia administración de medicamentos.*

3. That our Agency encourages patients who are capable of self-administering their own medications without assistance to do so. *Nuestra Agencia le recomienda que si es capaz de administrarse sus medicamentos sin asistencia, lo haga.*

4. That our Agency, provides unlicensed personnel who, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, helps the patient, who needs assistance and whose condition is medically stable, with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. *Nuestra Agencia provee personal no licenciado para ayudarlo en su administración de medicamentos que usted se puede administrar por si mismo, siguiendo las prescripciones escritas.*

5. That, for purposes of this informed consent, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, and topical opthalmic, otic, and nasal dosage forms, including solutions, suspensions, sprays, and inhalers. *Este consentimiento incluye controladas y no controlados medicamentos, como oral, topical, oftalmológicas, nasal, etc.*

I ______________________________ [patient, or patient's surrogate, or guardian, or attorney in fact's name], hereby state that I have read, and been fully informed of, the above facts and that I hereby request and consent to have home health aides assist me with my self-administered medications. *Yo certifico que leí y estoy completamente informado, y de acuerdo con la ayuda de la auxiliar de enfermera en la administración de medicamentos que puedo administrarme por mi mismo.*

Signed this the ___ day of _________________, _______. *Firmado en fecha.*

______________________________ ______________________________

Patient, or patient's surrogate, or guardian, or attorney in fact/*Firma del Paciente* (Title)

Sample 305.818.5940

MEDICATION MANAGEMENT CASE CONFERENCE

Patient Name:____ MR#___________________ Date:___________________
Case Conference with SN re: Medications management. During the last week patient/caregiver reports:
Compliance with Medications regime Yes ________ No _________
Patient/caregiver instructed in action /side effects/adverse effects reactions to ______________________________
Verbalizes understanding: Yes_____ No______ requires additional instructions___________
Adverse reactions/side effects noted No_____ Yes_____ (describe fully) ____
____
Physician contacted: No______ Yes_____Orders received:____
____
Other:____
____

____
Signature/Title

Date:_________________________
Case Conference with SN re: Medications management. During the last week patient/caregiver reports:
Compliance with Medications regime Yes ________ No _________
Patient/caregiver instructed in action /side effects/adverse effects reactions to ______________________________
Verbalizes understanding: Yes_____ No______ requires additional instructions___________
Adverse reactions/side effects noted No_____ Yes_____ (describe fully) ____
____
Physician contacted: No______ Yes_____Orders received:____
____
Other:____
____

____
Signature/Title

Date:_________________________
Case Conference with SN re: Medications management. During the last week patient/caregiver reports:
Compliance with Medications regime Yes ________ No _________
Patient/caregiver instructed in action /side effects/adverse effects reactions to ______________________________
Verbalizes understanding: Yes_____ No______ requires additional instructions___________
Adverse reactions/side effects noted No_____ Yes_____ (describe fully) ____
____
Physician contacted: No______ Yes_____Orders received:____
____
Other:____
____

Sample 305.818.5940

____
Signature/Title

Date:_________________________
Case Conference with SN re: Medications management. During the last week patient/caregiver reports:
Compliance with Medications regime Yes ________ No _________
Patient/caregiver instructed in action /side effects/adverse effects reactions to ______________________________
Verbalizes understanding: Yes_____ No______ requires additional instructions___________
Adverse reactions/side effects noted No_____ Yes_____ (describe fully) ____
____
Physician contacted: No______ Yes_____Orders received:____
____
Other:____
____

____
Signature/Title

MEDICATION SAFETY

(Spanish Translation on the back of this form)

Date: ________________________

Patient: _______________________________________MR#: ________________________

GOAL: At the completion of this discussion the client and/or caregiver is able to verbalize the safe use of medication.

- Store medication in their own, clearly marked, containers.
- Flush all expired medication down the toilet.
- Tell your doctor about all medication and vitamins you use.
- Call your doctor promptly if you notice any side effects or new symptoms. Keep record of all the medication you take each day.
- Take your pills with a full glass of water and be sure to drink all the water even if the pill went down with the first swallow.
- Know why you are taking a medication and what side effects may occur.
- Refill your medications before you are completely out of them.
- Do not take the medications you may be allergic or sensitive to.
- Shake medication for at least one full minute if told to do so.
- Keep medicines stored out of direct sunlight.
- Many foods and drinks react with medications. Ask for the correct way to take your medication.
- Remove foil wrap from all suppositories before use.
- Store medications at room temperature unless told to refrigerate.
- Consider purchasing a medic alert bracelet or necklace.
- Consult your health care provider if you have any questions.

DON'T:

- Take any medication not prescribed to you.
- Adjust your dosage without telling your doctor.
- Take medication without telling your doctor.
- Break open or crush pills without consulting with your health care provider.
- Stop taking antibiotics because you are feeling better.
- Warm medications in hot water or microwave.
- Keep poisons stored near medications.
- Leave pills or liquid medicine open and unattended on the counter.
- Take a double dose of any medication if you forget a dose.

I have been given written and verbal instructions in the safe and appropriate use of my medications. I understand the instructions given to me and will call the Agency if I have any questions.

PATIENT SIGNATURE: ______________________________________ DATE: _____________________________

WITNESS: ____

Sample
305.818.5940

SEGURIDAD DE LOS MEDICAMENTOS

Fecha: ________________________

Paciente: _______________________________________ MR#: ________________________

META: Al final de esta discusión el cliente y/o el representante puede verbalizar el uso seguro de las medicinas.

- Almacene la medicación claramente marcada en su propio envase.
- Descargar toda medicina expirada por el tragante.
- Infórmele a su Doctor todas las medicinas y vitaminas que usted usa.
- Contacte a su doctor urgente si nota algún efecto secundario o un síntoma nuevo. Mantenga un expediente diario de cada medicina que usted consume.
- Tome sus medicinas con un vaso de agua y asegúrese de tomárselo completo aunque la medicina se la haya tragado con el primer sorbo.
- Sepa la razón por la cual está usted tomando la medicina y los síntomas que le pueden causar.
- Obtenga sus medicinas antes que se le acaben completamente.
- No tome medicinas que le puedan causar alergia o sensibilidad.
- Si fuese indicado bata sus medicinas por un minuto completo.
- Mantenga sus medicinas fuera de la luz directa del sol.
- Muchos alimentos y bebidas reaccionan con la medicina. Pregunte la manera correcta de tomar sus medicinas.
- Evite mezclar alcohol con cualquier medicamento.
- Quite la envoltura de cada supositorio antes de usar.
- Almacene la medicina a temperatura ambiente a menos que este dicho que se refrigere.
- Considere comprar una pulsera o un collar que la comunique con los servicios de emergencia.
- Consulte con su proveedor del cuidado de la salud si usted tuviese alguna pregunta.

Sample 305.818.5940

NO:

- No tome cualquier medicamente que no le sea prescrito.
- No ajuste su medicina sin consultar con su médico.
- No tome medicinas sin consultar con su medico
- No rompa o mezcle las píldoras sin consultar con su médico o farmacéutico.
- No pare de tomar antibióticos aunque se sienta bien.
- No caliente sus medicinas en el microondas o con agua caliente.
- No almacene los venenos cerca de sus medicinas.
- No deje las píldoras o las medicinas liquidas abiertas o desatendidas en el mostrador.
- No tome una dosis doble de cualquier medicina si usted se olvida de una dosis.

Me han dado la instrucción escrita y verbal en el uso y el cuidado apropiado de mis medicamentos. Entiendo las instrucciones dadas a mi y llamare a la agencia si tengo alguna pregunta.

FIRMA DEL PACIENTE: ____________________________________ FECHA: ____________________________

TESTIGO: ____

ASSESSMENT FOR SELF-ADMINISTRATION OF MEDICATIONS

PATIENT NAME: ____ ID # ____________________

QUESTIONARY	FULLY CAPABLE	ABLE WITH ASSIST	UNABLE	NOT APPLICABLE
1-Patient can state name of medication and what it is used for?				
2-Patient can read print on prescription labels?				
3-Patient knows common side-effects of each medication?				
4-Patient knows at what time medications are to be taken?				
5-Patient knows the proper dosages for each medication?				
6-Patient can demonstrate good hand wash techniques prior to and following medication administration?				
7-Patient can show the correct measure amount of medication from the container?				
8-Patient can demonstrate secure storage for medication kept in room?				
9-Patient knows the situations that are safe for the administration of the PRN medicines?				
10-Patient is able to open and close medication containers?				
11-Patient knows how to administer eye drops, ear-drops or eye ointment with proper procedures?				
12-Patient knows how to apply topical ointments, creams, or transdermal patches with proper procedures?				
13-Patient can administer suppositories with proper procedures?				
14-Patient can administer inhalant medications with proper procedures?				
15-Patient can demonstrate administration of subcutaneous or intramuscular injections with proper procedures?				
16-Patient knows safe administration of all the prescribed medications and over the counter interactions?				

Sample
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INTERDISCIPLINARY TEAM EVALUATION

IS PATIENT SAFE TO TAKE OWN MEDICATIONS: □YES □NO
PATIENT WILL NEED ASSISTANCE WITH HIS MEDICATIONS: □YES □NO
PATIENT WILL NEED A WEEKLY MEDICATION SETUP AND OR REMAIDER FOR MEDS: □YES □NO
PATIENT WILL NEED FURTHER TEACHING ON MEDICATIONS: □YES □NO

TITLE AND SIGNATURE: ____ DATE: ______/______/20_____

FALL RISK ASSESSMENT / REASSESSMENT

PATIENT: ____ ID #:_____________________

RISK	Yes	No	IF "YES" RISK REDUCTION STRATEGIES PROVIDED	Yes	No
1-Impaired balance or mobility			**Educated to use assistive devices and to rise slowly from sitting to standing position. Pt. educated to call for assistance before getting out of bed or getting up from chair**		
2- Musculoskeletal problems			**Educated to use assistive devices and to rise slowly from sitting to standing position**		
3-cognitive impairment (short term memory changes or poor impulse control, etc)			**Educated caregiver in appropriate supervision for Activities of Daily Living**		
4- Nutritional problems affecting Activities of Daily Living			**Educated in Doctor ordered diet.**		
5-Use of narcotics, hypnotics, analgesics, psychotropic's, laxatives, diuretics, sedatives or antihypertensive medications, including multiple medications (polypharmacy = 10 or more medications)			**Educated in side effects of medications, including potential for increased fall risk due to side effects of drowsiness, motor disturbances and ataxia**		
6- History of previous falls			**Educated in safe ambulation, use of assistive devices and relevant home safety issues.**		
7- Abnormal sleep pattern for patient			**Educated in appropriate sleep pattern**		
8- Specific environmental issues			**Improve lighting. Needed objects should be placed within easy reach. Remove throw rugs. Keep floors and stairs free of clutter**		

PLEASE REVIEW AND MARK YES OR NO BELOW

	YES		NO	
	YES		**NO**	**Patient with recent or ongoing changes in Level of Independence.**
	YES		**NO**	**Patient with recent or ongoing Sensory Changes**
	YES		**NO**	**Patient with recent or ongoing Communication Difficulties**
	YES		**NO**	**Risk of Falling communicated to Patient and or Caregiver. Strategies for prevention provided to patient and or caregiver**

_______________________________________ ____/_____/20___

Name/ Signature/Title of individual completing this form. Date

____/_____/20____ _______________ ____/_____/20____ _______________

Updated Signature/Title Updated Signature/Title

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SIMPLE STEPS TO HELP PATIENT REDUCE RISK OF FALLS
PASOS SENCILLOS PARA DISMINUIR RIESGOS DE CAIDAS

The Dangers of Falling

Falls are one of the main causes of injury in people over age 65. An older person who falls may take longer to get better than a younger person. And, after a fall, an older person is more likely to have problems that don't go away. This is why it's a good idea to take steps to keep from falling.

You can Help Prevent Falls

Changing is sometimes easier said than done. But keep in mind that even small changes can make you less likely to fall.

Los riesgos de caerse.

Una de las causas principales de las lesions en las personas mayors de 65 anos son las caidas. Posiblemente, la recuperacion de una persona mayor que se cae sea mas lenta que la de una persona mas joven. Por esto, conviene tomar precauciones para prevenir las caidas.

Usted puede hacer algo para evitar las caidas

A menudo, es mas facil hablar de los cambios que realmente llevarlos a cabo. Pero tenga en cuenta que aun los cambios mas pequenos pueden disminuir el riesgo de caerse.

Make your health a priority

Chronic conditions increase your Fall Risk like diabetes, high or low blood Pressure and arthritis. They may cause problems with movement, balance, or vision. And certain medications you take for them may have side effects, such as dizziness or drowsiness.

What to do to Help Prevent Falls

- You may have at least yearly medical exam annual
- Get your eyes checked at least once a year
- Get your hearing checked at least every other year
- Have your doctor check your inner ear for balance problems
- Get the right Nutrition
- Make changes in your Living Space such as: Remove hazards, add safety devices, and improve Lighting
- Learn to Move Safely , Plan your movements
- If you need a Walking Aid such as cane, walker please use your devices
- Stay as Active as You Can

Su salud debe tener prioridad

Afeccciones cronicas aumentan el riesgo de caerse tales como diabetes, la alta o baja presion arterial y la arthritis. Esto puede provocarle dificultates de vision equilibrio o movimiento. Y ciertos medicamentos que toma pueden tener efectos secundarios como mareos o somnolencia.

Que hacer para ayudar a Prevenir Caidas

- **Usted debe de tener por lo menos un examen medico anual**
- **Hagase un control de la vista por lo menos una vez por ano**
- **Hagase un control de audicion por lo menos cada dos anos**
- **Pidale a su medico revisar el interior de los oidos para detector problemas que afecten su equilibrio.**
- **alimentese correctamente**
- **Haga cambios en su vivienda tales como: Quitar cosas peligrosas, poner dispositivos de seguridad y mejore la iluminacion**
- **Aprenda a moverse de forma segura, Planee sus movimientos**
- **Si necesita apoyo para caminar tal como, baston o andadera por favor usarlo**
- **Mantengase lo mas activo possibl**e

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IF YOU FALL

Falling is not something that we want to think about

How to Prepare

Have someone check on you daily

Keep a list of emergency numbers near the phone

Always have a way to call for help

WHAT TO DO IF YOU FALL

Above all, try to stay calm

If you start to fall, try to relax your body to reduce The impact of the fall

After you fall, if you have press your monitor button Or phone for help. Call 911 if needed

SI SE CAE

Caerse no es algo en lo que queremos pensar

Como Prepararse

Tenga a alguien que este pendiente de usted todos los dias

Coloque una lista con numerous de emergencia cerca del telefono

Tenga siempre una forma de pedir ayuda.

QUE DEBE HACER SI SE CAE

Ante todo , trate de mantener la calma

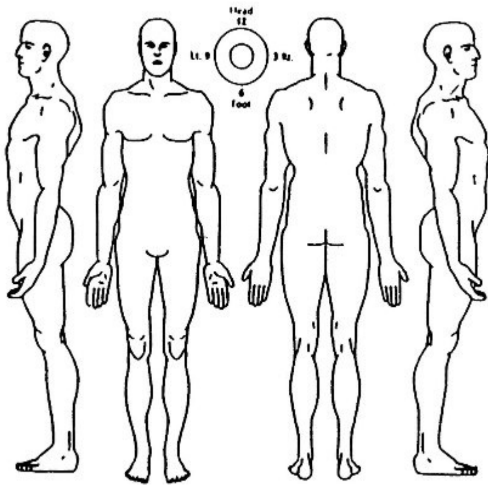
si comienza a caer, trate de relajar el cuerpo para reducir el impacto de la caida

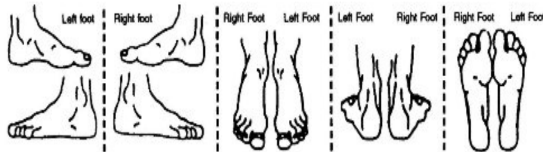
Luego de la caida, presione el boton del sistema de monitor si lo tiene o pida ayuda telefonicamente. Llame al 911 si es necesario.

Wound Treatment Plan & Flow Sheet

Patient Name ____________________________ Who is performing care? ☐ patient ☐ caregiver ☐ nurse ☐ other: ______________________

Signature of Clinician: ____________________________________ **Date:** ________________________





Date/Time	Wound #	Wound #	Wound #	Wound #
Wound Type	☐ Skin Tear ☐ Incision ☐ Pressure Ulcer ☐ Leg Ulcer ☐ Foot Ulcer ☐ Excoriation	☐ Skin Tear ☐ Incision ☐ Pressure Ulcer ☐ Leg Ulcer ☐ Foot Ulcer ☐ Excoriation	☐ Skin Tear ☐ Incision ☐ Pressure Ulcer ☐ Leg Ulcer ☐ Foot Ulcer ☐ Excoriation	☐ Skin Tear ☐ Incision ☐ Pressure Ulcer ☐ Leg Ulcer ☐ Foot Ulcer ☐ Excoriation
Stage (Pressure Ulcer):	☐ I ☐ II ☐ III ☐ IV ☐ NS-nonstageable due to eschar	☐ I ☐ II ☐ III ☐ IV ☐ NS-nonstageable due to eschar	☐ I ☐ II ☐ III ☐ IV ☐ NS-nonstageable due to eschar	☐ I ☐ II ☐ III ☐ IV ☐ NS-nonstageable due to eschar
Size (in cm.)	Length _________ Width _________ Depth _________	Length _________ Width _________ Depth _________	Length _________ Width _________ Depth _________	Length _________ Width _________ Depth _________
Wound Thickness	☐ Full thickness ☐ Partial-thickness ☐ Other ________	☐ Full thickness ☐ Partial-thickness ☐ Other ________	☐ Full thickness ☐ Partial-thickness ☐ Other ________	☐ Full thickness ☐ Partial-thickness ☐ Other ________

Color Red/Pink= granulating Yellow= slough Black= eschar	☐ Red _______% ☐ Pink _______% ☐ Yellow ______% ☐ Black________% ☐ Other:	☐ Red _______% ☐ Pink _______% ☐ Yellow ______% ☐ Black________% ☐ Other::	☐ Red _______% ☐ Pink _______% ☐ Yellow ______% ☐ Black________% ☐ Other::	☐ Red _______% ☐ Pink _______% ☐ Yellow ______% ☐ Black________% ☐ Other::
Drainage (see KEY below)	Color __________ Amount ________ **Consistency** Thick ☐ Thin ☐	Color __________ Amount ________ **Consistency** Thick ☐ Thin ☐	Color __________ Amount ________ **Consistency** Thick ☐ Thin ☐	Color __________ Amount ________ **Consistency** Thick ☐ Thin ☐
Odor	☐ Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No
Tunneling	☐Yes ☐ No ___o'clock	☐Yes ☐ No ___o'clock	☐Yes ☐ No ___o'clock	☐Yes ☐ No ___o'clock
Undermining	☐Yes ☐ No ___o'clock	☐Yes ☐ No ___o'clock	☐Yes ☐ No ___o'clock	☐Yes ☐ No ___o'clock
Wound Edges	Color __________ Distinct ☐ Yes ☐ No Rolled ☐ Yes ☐ No Irregular ☐ Yes ☐ No Steep ☐ Yes ☐ No (leg ulcers)	Color __________ Distinct ☐ Yes ☐ No Rolled ☐ Yes ☐ No Irregular ☐ Yes ☐ No Steep ☐ Yes ☐ No (leg ulcers)	Color __________ Distinct ☐ Yes ☐ No Rolled ☐ Yes ☐ No Irregular ☐ Yes ☐ No Steep ☐ Yes ☐ No (leg ulcers)	Color __________ Distinct ☐ Yes ☐ No Rolled ☐ Yes ☐ No Irregular ☐ Yes ☐ No Steep ☐ Yes ☐ No (leg ulcers)
Periwound Surrounding skin	☐ Intact ☐ blistered ☐ Edema ☐ calloused ☐ Red ☐ macerated ☐ Other	☐ Intact ☐ blistered ☐ Edema ☐ calloused ☐ Red ☐ macerated ☐ Other	☐ Intact ☐ blistered ☐ Edema ☐ calloused ☐ Red ☐ macerated ☐ Other	☐ Intact ☐ blistered ☐ Edema ☐ calloused ☐ Red ☐ macerated ☐ Other
Wound Care Order				

KEY for Wound Drainage
Amount: S = stains dressing D = dampens dressing SO = soaks dressing
Color: S = serous P = purulent SS = serosanguinous G = green (may indicate pseudomonas), Y = yellow (may indicate staph aureus)

Stages of Pressure Ulcers
I Nonblanchable erythema of intact skin. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.
II Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents as an abrasion, blister, or shallow crater.
III Full thickness skin loss involving damage/necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. Undermining may/may not be present.
IV Full thickness skin loss with excessive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and/or tunneling may be present.
Tunneling: also called a sinus tract; involves small portion of wound edge with path of tissue destruction
Undermining: area of tissue destruction extending under intact skin along periphery of wound (overhangs the wound edges); involves significant portion of wound edge

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Consent for Continuation/Start of Care

I, ___________________________, hereby authorize consent for Home Health Services to be rendered solely by . In the event of hospitalization, upon my discharge from Hospital/Outpatient center, , will immediately continue providing services.

Yo, __________________________, autorizo a la compañia , a brindarme los servicios de Home Health. Si soy hospitalizado, cuando sea finalizada mi estancia en el hospital o centro de rehabilitación, tambien continuará con mis servicios de Home Health.

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____ ____________________

Signature of Patient/Authorized Representative — Date/Fecha
Firma del Paciente/Representante Autorizado

____ ____________________

Relationship of Authorized Representative — Date/Fecha
Relación con Representante Autorizado

____ ____________________

Witness/Testigo — Date/Fecha

WHITE - CHART

YELLOW HOME CHART

Hospitalization Risk Assessment

Purpose: Screening tool to identify those at risk for hospitalization.
Patient Name: ____ Record # _______________
Date: ___________________

Prior pattern: Check all that apply	
❑ > 1 Hospitalizations or ER visits in the past 12 months	❑ History of falls * *(Complete Falls Risk Assessment)*
Chronic conditions: Check all that apply (M0230/M0240)	
❑ CHF	❑ Chronic skin ulcers *(Wound consult if indicated for any wounds)*
❑ Diabetes	
❑ COPD	❑ HIV/AIDS
Risk Factors: Check all that apply	
❑ Discharged from hospital or skilled nursing facility (M0175)	❑ Help with managing medications needed (M0780) ► ★
❑ More than 2 secondary diagnoses (M0240)	❑ Non-compliance with medication regimen ♦ ★
❑ Low socioeconomic status or financial concerns ♦	❑ Confusion (M0570) ♦ ★
❑ Lives alone (M0340) ►♦	❑ Pressure ulcer (M0445) ★
❑ Inadequate support network ♦	❑ Stasis ulcer (M0468) ★
❑ ADL assistance needed►	❑ Short life expectancy (M0280) ■
❑ Home safety risks ► ♦	❑ Poor prognosis (M0260) ■
❑ Dyspnea (M0490) ► ★	❑ Low literacy level ♦

►Consider Therapy referral (PT, OT, ST)	♦ Consider MSW referral	■ Consider Hospice referral	★Consider RN referral, if not ordered

Total # of checked boxes is ___. **Your agency may want to select a threshold score to target patients at high risk.** (*For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization.* Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)

Consider implementing any of the following interventions, if patient is at risk for hospitalization:		
Referrals: ❑ SN ❑ PT ❑ OT ❑ ST ❑ MSW ❑ HHA ❑ Dietary Consultant ❑ Other ______________	❑ Medication Management Reconciliation • Assess patient's: knowledge, ability, resources and adherence • Education	❑ Patient/family education ❑ Enrollment into a disease management program (specify): ______________
❑ Hospice/Palliative Referral	❑ Phone Monitoring	Immunizations ❑ Influenza ❑ Pneumonia
❑ Individualized Patient Emergency Care Plan	❑ Front-loading Visits	❑ Care Coordination (Physicians, hospitals, nursing homes…)
❑ Fall Prevention Program	❑ Telemonitoring	❑ Other: ______________

Consider notification of any/all of the following if patient is at risk for hospitalization:

❑ Patient/family/caregiver	❑ Interdisciplinary Team	❑ On Call Staff	❑ Payer: (e.g. Managed Care Organizations)
❑ Physician	______________	❑ Agency Case Manager	❑ Other:

Clinician Signature: ____ Date:___________

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CAREGIVER / PATIENT AFFIDAVIT

Patient Name: ______________________________ Date: ________________

Attending Physician: ______________________________ Medicare #: ________________

Type of Visit: Injectable medication administration. Type of Medication: ____________________

Other Type of Visit/Service: ____

Name of Caregiver(s) if any: ____

Relationship to Patient: ____

Reason caregiver / Patient unable to administer injectable medication or provide other type of service:

___ Caregiver/Patient refused to be instructed, explain:

____

____

___ Caregiver Busy work schedule, explain:

____

____

___ Functional limitations, explain:

____

____

___ Other

____

____

Affidavit

I, ______________________________, hereby swear or affirm that these statements are true and correct.

______________________________ ________________

Signature of Caregiver/Patient Date

____

Witness

____

Agency Representative, Signature, Title

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IN-HOME CALENDAR

SOC DATE ____/____/____

CARE MANAGER ____________________

INSTRUCTIONS. Circle or highlight the appropriate month and write in dates accordingly. Proceed by specifying all visits ordered by designating discipline(s) and time(a) for each day. (See Discipline legend below.)

JANUARY **FEBRUARY** **MARCH** **APRIL** **MAY** **JUNE**

JULY **AUGUST** **SEPTEMBER** **OCTOBER** **NOVEMBER** **DECEMBER**

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

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DISCIPLINE:

SN	Skilled Nursing	PT - Physical Therapy
HHA	Home Health Aide	OT - Occupational Therapy
MSS	Medical Social Services	SLP - Speech Language Pathology

PATIENT/CLIENT NAME - Last. First, Middle initial	ID#

Patient Name: ______________________________ **MR#** ___________________
Nombre del Paciente

Beneficiary- Elected Transfer
Forma de Elección de transferencia del Paciente

The use of the HIQH (RHHI INQUIRY SYSTEM) has indicated that the beneficiary is under an active episode of care with another Home Health Agency. **The transfer has been elected by the patient or patient representative.** *El uso del sistema informativo HIQH/RHHI indico que el beneficiario esta bajo servicio con otra Agencia,* ***transferirse a nuestra Agencia ha sido elegido por el paciente/representante.***

Complete the following:

1. **The original RHHI** inquiry system was accessed on (date) ____________ it was discovered that the patient has an active episode under care with the following agency: ____.
   Fecha en que fue revisado el sistema.

2. The patient's physician (name) _________________________________ was contacted on (date) _____________ and approved this transfer.
   El doctor del paciente fue contactado y aprobó el cambio.

3. The patient or patient care giver was notified that the initial H.H.A will no longer receive Medicare payment on (date of transfer) ________________ and **agreed to the transfer.**
   El paciente/representante fue notificado que la anterior Agencia no recivirá más pagos por los servicios a partir de la transferencia.

Name of person contacted: ____
Nombre de la persona contactada

Relationship: ____
Relación

4. The initial H.H.A was contacted on (date of transfer) _______________ and notified of the transfer to our agency.
   Fecha en que la anterior Agencia fue contactada y notificada de la transferencia

______________________________ ______________________
Patient's/Caregiver Signature Date
Firma del paciente/representate *Fecha*

______________________________ ______________________
Signature/Title of Agency Representative Date
Firma del representante de la Agencia/Título *Fecha*

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ON-CALL LOG

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Emp: ph: Date:	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**
Emp: **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**
Emp: **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**
Emp: **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**
Emp: **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**
Emp: **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**
Emp: **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**
Emp: **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**
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Emp: **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**	**Emp:** **ph:** **Date:**

Sample
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Observation:____

____

____

ON-CALL REPORT / COMPLAINT REPORT

Date: ______________________ Time: ___________________

Employee: ____

Report related Patient: ____________________________ MR:________________

Incident:

____

____

____

____

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Action taken:

____

____

____

MD reported: ____ Yes ____ No Comment:_______________________________

____

Signature

Patient Name: ____ MR #: __________________

Transfer to (In Patient Facility Name): ____

Date of Transfer: _____________________ Pt's Physician: ____________________________

☐ MD notified of transfer, date: _______________ ☐ ABSTRACT Summary faxed to MD
☐ ABSTRACT summary faxed to In Patient Facility, date: ________________
☐ ABSTRACT summary delivery to patient

ABSTRACT SUMMARY REPORT

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____ _________________________
Staff making report/Title Date

SUPERVISORY REPORT

Patient Name________________________________ MR# __________ Date ____________

Staff supervised Name________________________________

Aide/LPN/staff present: ❒ Yes ❒ No

❒ Medicare ❒ Medicaid ❒ Other

❒ Discipline Involved (Supervisory visit for:) ❒ LPN ❒ HHA ❒ PTA ❒ Other (Specify): ____________________

❒ Verbal approval for Supervisory Visit obtained from:

❒ Patient ❒ Other: ________________________________

Name/Relationship

KEY:

MR= Meets Requirements – Fully meets high standards expected. Performance is *completely satisfactory*.

NI = Needs Improvement – Some additional work/emphasis or experience is needed; is capable of improving performance.

U = Unsatisfactory - Falls short of expected requirements, standards, or objectives. Significant improvement needed.

N/A= Not Applicable

Comment: If expectations are *not met* or *are exceeded* please specify:____________________

____

	Field Staff SUPERVISORY CRITERIA	MR	NI	U	N/A	Observed Yes/No
1.	Reports to assignments on visit schedule, and on time. Vital signs and all procedures taken					
2.	Follows written Plan of Care. Report any need of Medication/Emergency Form Updates					
3.	Documents Care/Observations accurately. Use of Blood Sugar/Blood Pressure Log if applicable					
4.	Reports changes in condition/needs appropriately. Use of Team Communication Form, participate in Case Conferences.					
5.	Maintains client confidentiality, following all HIPAA guidelines. Staff are following community cultural diversity, non discrimination care.					
6.	Maintains clean/safe client environment. Staff was prepared with appropriate supplies and equipment as needed					
7.	Adheres to Agency Policies and Procedures. Use Physician/Agency Communications when needed.					
8.	Exhibits good grooming habits and appropriate attire, use ID badge, correct dress code. Maintain Ethic manners.					
9.	Maintains positive and helpful attitude towards client, patient able to participate in the care planning process and in his/her care					
	OBSERVED DURING VISIT					
10.	Demonstrates proper hand washing technique and follows Agency's hand hygiene guidelines.					
11.	Follows Standard/Universal Precautions, use of PPE. Demonstrate adherence to Bag Techniques, Gloves changes.					
12.	Demonstrates proper body mechanics.					
13.	Follows safety measures/goals.					
14.	Performs assigned duties/procedures in a safe and adequate manner.					

Comments/Recommendations (Include instructions given/training demonstrated) Patient's feedback:

❒ Patient has a continued need for services ❒ Meets Homebound Criteria ❒ Satisfied with Services

Supervisor Signature/Title

Employee Signature (when applicable)

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Braden Risk Assessment Scale

NOTE: Bed and chairbound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Patients with established pressure ulcers should be reassessed periodically.

Patient Name: ______________________ Med. Rec. Number: ______ Date: ____________

Sensory Perception	**1. Completely Limited**	**2. Very Limited**	**3. Slightly Limited**	**4. No Impairment**	*Indicate Appropriate Numbers Below*
Ability to respond meaningfully to pressure-related discomfort	Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
Moisture	**1. Constantly Moist**	**2. Very Moist**	**3. Occasionally Moist**	**4. Rarely Moist**	
Degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always, moist. Linen must be changed at least once a shift.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry. Linen only requires changing at routine intervals.	
Activity	**1. Bedfast**	**2. Chairfast**	**3. Walks Occasionally**	**4. Walks Frequently**	
Degree of physical activity	Confined to bed.	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	
Mobility	**1. Completely Immobile**	**2. Very Limited**	**3. Slightly Limited**	**4. No Limitations**	
Ability to change and control body position	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent though slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	
Nutrition	**1. Very Poor**	**2. Probably Inadequate**	**3. Adequate**	**4. Excellent**	
Usual food intake pattern	Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or I.V.'s for more than 5 days.	Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	
Friction and Shear	**1. Problem**	**2. Potential Problem**	**3. No Apparent Problem**		
	Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		

NOTE: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers. (15 or 16 = low risk; 13 or 14 = moderate risk; 12 or less = high risk)

Total Score: ____

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Sample 305.618.5940