AGENCY NAME

AGENCY ADDRESS
CITY
Phone
Fax

Assessment Date _____

Reassessment Date _____

Significant Change _____

☐ Stable & Predictable

NURSING ASSESSMENT / HEALTH CARE REPORT

General Information

Last Name _____ First Name _____ M.I. _____ DOB _____

Primary Contact Person (Name & Relationship)
_____ Phone#_____
Secondary Contact Person (Name & Relationship)
_____ Phone #_____

Living Situation

Dwelling: ___Apartment ___House ___ Other_____

Lives Alone: Yes___ No____ If NO, identify all individuals living in the home.
_____
_____

If other individuals live in the home, list the hours, days available and services they are able to assist with care giving: _____

_____

Hospitalization (since last assessment)

Hospital Name:_____ Address _____
Phone# _____ Hospitalization Date:_____
Diagnoses:_____
_____

Current Status

Is Person alert? __Always __Sometimes __Never
Recent Significant weight loss? _____ Gain? _____
If so, how much loss? _____ Increase? _____

Can person direct home care worker/DSW __ Yes
If no, who is responsible for directing care?
_____

Sensory Impairments

Vision:

□ No problems □ Glasses □ Blurring □ Headaches □ Diplopia
□ Inflammation □ Cataracts □ Glaucoma □ Puffy lids □ Jaundice (sclera)
Comment: _____

Hearing:

□ No problems □ Limited □ Hearing Aid □ Pain
□ Ringing □ Discharge □ Feeling of Fullness
Comment: _____

Speech (If history of Swallow Study completed please note in comments)

□ Clear □ Slurred □ Non-English speaking □ Can understand
□ Can express □ Dentures □ Lesions in mouth Last Dental Appointment: _____
Comment: _____

NEURO	Mental/LOC Status	Oriented to: □ Person □ Place □ Time □ Situation/Event □ Alert □ Sedated □ Restless □ Sleepy/arousable □ Lethargic □ Unresponsive □ Responds only to pain □ Agitated □ Confused □ Combative □ Hallucinating □ Anxious □ Wanders □ Depressed □ Impaired Judgment □ Other _____ □ Pain Level 0 (none) to 10 (maximum) _____
NUTRITION	Diet	□ Regular □ Low-Na □ Low Chol □ ADA □ Soft □ Puree □ Tube fed
	Appetite	□ Good □ Fair □ Poor w/Weight loss
	Interfering Factors	□ Nausea □ Vomiting □ Epigastric Pain □ Belching frequently □ Indigestion □ Peg Tube □ Altered Taste □ Flatulence □ N/A **Difficulties In:** □ Chewing □ Swallowing □ Feeding Self
RESPIRATORY	History	□ Emphysema □ Asthma □ Exposed to TB □ Last Chest X-ray_____ □ Frequent colds □ Barrel chest □ Chest rises evenly bilaterally □ Dyspnea □ Pneumonia □ Cough □ O2 __L/min.____
	Smoker	□ Never □ Former □ Current: _____packs per day for _____years
CARDIAC	Edema	□ None □ Edema +1/+2/+3/+4 Location:_____
	Skin Temperature	□ Normal □ Hot □ Cool
	Skin Color	□ Normal □ Fair □ Pale
	Capillary Refill	□ Normal □ ≤ 3secs □ ≥ 3secs
	Rhythm/Heart Sounds	□ Regular □ Irregular
SKIN	Skin Integrity	□ Intact □ Ulcer □ Purpura □ Skin tears □ Other:_____ Location:_____
	Wound Abrasion	□ None □ Location:_____ Drainage: □ None □ Other:_____ □ Dressing □ Clean □ Dry □ Intact
	Surgical incision/Site	□ None □ Location:_____ Drainage: □ None □ Other:_____ □ Dressing □ Clean □ Dry □ Intact
	Other:	Briefly explain:_____

Elimination:

Bowel Incontinence ____ **Never** ____ **Sometimes** ____ **Always**

Does individual have bowel movement daily? ____ **Yes** ____ **No If no, how often?**_____

Bladder Incontinence _____ **Never** _____ **Sometimes** ____ **Always**

Person's Ability to Take/Administer Medication:

Totally Dependent ____ **Never** ____ **Sometimes** ____ **Always**
Needs Reminding ____ **Never** ____ **Sometimes** ____ **Always**
Non - Compliant ____ **Never** ____ **Sometimes** ____ **Always**
Needs help preparing ____ **Never** ____ **Sometimes** ____ **Always**

Is DSW certified to administer medications? ____ **Yes: (16 hr Med Course/ or CMA) No** _____
If person is insulin dependent and takes injection who is administering injections?

_____

Insulin injections administered how many times per week? _____

The administration of injections is a complex task. DSW's ARE NOT allowed to give injection's
Note: Emergency Epi Pen allowed with RN delegation and training

Medical Treatment (Check all that apply):For non-complex tasks refer to RN Delegation form and specific trainings completed.

__ **Decubitus Care** __ **Monitor Vital Signs** __ **Ambulation Exercise**
__ **Dressings- Simple** __ **Tube Feeding** __ **Suctioning – no deep suctioning allowed**
__**Catheter Care** __ **Tube Irrigation** __ **Enema**
__ **Dressings-Sterile-(HH)** __ **Oxygen Administration –Needs Skilled Nsg** __ **Ventilator - Needs Skilled Nsg**

Service Needs:

Ambulate Inside ___ **Without help** ___ **With Walker/Cane/Personal Assistance** ___ **With Wheelchair** ___ **Unable**
Ambulate Outside ___ **Without help** ___ **With Walker/Cane/Personal Assistance** ___ **With Wheelchair** ___ **Unable**
Get Up from Seated Position ___ **Without help** ___ **With Walker/Cane/Personal Assistance** ___ **Hoyer Lift**
Get Up from bed ___ **Without help** ___ **With Walker/Cane/Personal Assistance** ___ **Hoyer Lift**

Transfer to:
Commode ___ **Without help** ___ **With Walker/Cane/Personal Assistance** ___ **Hoyer Lift**
Wheelchair ___ **Without help** ___ **With Walker/Cane/Personal Assistance** ___ **Hoyer Lift**

Individuals Personal Service Needs:

Grooming ___ **No Assist** ___ **Partial Assist** ___ **Total Assist**
Dressing ___ **No Assist** ___ **Partial Assist** ___ **Total Assist**
Bathing ___ **No Assist** ___ **Partial Assist** ___ **Total Assist**
Feeding ___ **No Assist** ___ **Partial Assist** ___ **Total Assist**
Meal Prep ___ **No Assist** ___ **Partial Assist** ___ **Total Assist**
Laundry ___ **No Assist** ___ **Partial Assist** ___ **Total Assist**

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Grocery Shopping ___ **No Assist** ___ **Partial Assist** ___ **Total Assist**
Housecleaning ___ **No Assist** ___ **Partial Assist** ___ **Total Assist**

Certification:

This assessment is based on personal observation of the person. ___ **Yes** ___ **No**

Is any other agency providing services in the home to the person? ___ **Yes** ___ **No**
If YES, List the Agency Name: _____ Services _____
Phone# _____

ADDITIONAL OBSERVATIONS/COMMENTS:(List any ER visits since last assessment)

_____
_____
_____
_____

Program Considerations:
Complex tasks: those tasks only a nurse must perform:

_____

Non-complex tasks: those tasks the DSW will perform for this individual. (Delegation forms present- see below)

_____

List of trainings required to meet individual specific needs as addressed by Nursing /Health Care Assessment and or POC.

_____

_____

Review of, or initiation of RN Delegation forms required for non complex tasks: ____**Yes** ____**No**

_____
Printed Name of RN completing assessment

_____ _____
Signature of RN completing assessment Date

_____ _____
Administrator Signature (if required) Date