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HOME HEALTHCARE ASSESSMENT

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Client: _____



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Client: _____

PART ONE—Data Collection

Client: _____

Client Name			
Client Address			
Client Phone		Client DOB	
Client Social Security Number			

- Medical Alert Device? Yes No
 Medical Alert Bracelet? Yes No
 DNR? Yes* No
 Advance Directive? Yes* No

*Copy to be kept in Plan of Care Manual

Primary Language
Secondary Language

Other Agencies or Personnel Providing Care/Service	By...	Type of Service...

DIAGNOSES/MEDICAL HISTORY

ALLERGIES (other than food or medication allergies; e.g., seasonal, creams, lotions)

Client: _____



MEDICATION PROFILE

KNOWN ALLERGIES			
Physician		Physician's Phone	
Pharmacy		Pharmacy's Phone	

MEDICATION	<input type="checkbox"/> NEW <input type="checkbox"/> CHANGE				
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			
MEDICATION	<input type="checkbox"/> NEW <input type="checkbox"/> CHANGE				
PHARMACY					
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			

Client: _____



MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			
MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
PHARMACY					
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			
MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
PHARMACY					
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			

Client: _____



MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			
MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
PHARMACY					
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			
MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
PHARMACY					
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			

Client: _____



MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			
MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
PHARMACY					
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			
MEDICATION		<input type="checkbox"/> NEW			
		<input type="checkbox"/> CHANGE			
PHARMACY					
DIAGNOSIS, ACTION					
SIDE EFFECTS, INSTRUCTIONS					
DOSAGE		FREQUENCY		TIMES	
D/C DATE		ENTRY MADE BY, DATE			

Client: _____

CONTACT, SUPPORT AND EMERGENCY INFORMATION

PHYSICIAN NAME	
PHONE	()
ADDRESS	
TYPE	<input type="checkbox"/> Primary care <input type="checkbox"/> Specialist—Type _____
LAST APPOINTMENT DATE	

PHYSICIAN NAME	
PHONE	()
ADDRESS	
TYPE	<input type="checkbox"/> Primary care <input type="checkbox"/> Specialist—Type _____
LAST APPOINTMENT DATE	

PHYSICIAN NAME	
PHONE	()
ADDRESS	
TYPE	<input type="checkbox"/> Primary care <input type="checkbox"/> Specialist—Type _____
LAST APPOINTMENT DATE	

PRIMARY PHARMACY	
PHONE	()
ADDRESS	

SECONDARY PHARMACY	
PHONE	()
ADDRESS	

Client: _____

SUPPORT	
MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Does client live with anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No Name(s): _____ _____ Relationship(s): _____ _____

Other Support			
Name			
Relationship			
Home Phone	()	Work Phone	()
How does she/he provide assistance?			
What is her/his availability?			
Other Support			
Name			
Relationship			
Home Phone	()	Work Phone	()
How does she/he provide assistance?			
What is her/his availability?			
Other Support			
Name			
Relationship			
Home Phone	()	Work Phone	()
How does she/he provide assistance?			

Client: _____

Emergency Contact(s)				
Name				
Relationship				
Home Phone	()	Work Phone	()	Other Phone ()
Name				
Relationship				
Home Phone	()	Work Phone	()	Other Phone ()
Name				
Relationship				
Home Phone	()	Work Phone	()	Other Phone ()

Medical Equipment Supplier

NAME	
PHONE	()

Local Hospital

HOSPITAL	
PHONE	()

Other _____

NAME	
PHONE	()

Client: _____

PART TWO-- Assessments

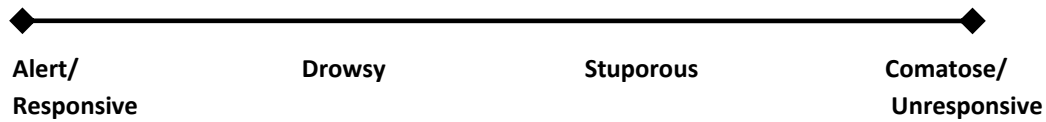
Client: _____

MENTAL/EMOTIONAL STATUS

- | | | |
|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Alert | <input type="checkbox"/> Combative | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Confused | <input type="checkbox"/> Isolated |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Lethargic |
| <input type="checkbox"/> Calm | <input type="checkbox"/> Depressed | <input type="checkbox"/> Unresponsive |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Withdrawn |

NOTE: Administer the MMSE instrument. Upon completion, record the "level of consciousness", raw score and severity of cognitive impairment (using provided norms data).

Assessment of level of consciousness



MMSE raw score: _____ (30 point maximum)

MMSE-Determined Level of Cognitive Impairment (using normative data):

COMMENTS/NOTES:

Client: _____

SYSTEMS ASSESSMENT

RESPIRATORY

- | | |
|---|--|
| <input type="checkbox"/> Asthma
<input type="checkbox"/> COPD :
<input type="checkbox"/> Chronic Bronchitis
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Lung Cancer
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Pneumonia
<input type="checkbox"/> O ₂ Therapy
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Smoking
<input type="checkbox"/> Tuberculosis |
|---|--|

Comments :

CARDIOVASCULAR

- | | | |
|---|--|---|
| <input type="checkbox"/> Angina/Chest Pain
<input type="checkbox"/> Arrhythmias _____
<input type="checkbox"/> CHF
<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Cyanosis
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Dizziness
<input type="checkbox"/> Edema
<input type="checkbox"/> Fainting
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Hypotension | <input type="checkbox"/> Lightheadedness
<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Peripheral Vascular Disease |
|---|--|---|

Comments :

HEMATOLOGICAL/ENDOCRINE/IMMUNE

- | | | |
|--|---|--|
| <input type="checkbox"/> Addison's Disease
<input type="checkbox"/> AIDS
<input type="checkbox"/> Anemia
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Cushing's
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Graves' Disease
<input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Leukemia
<input type="checkbox"/> Lupus
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Thyroid |
|--|---|--|

Comments :

Client: _____

GASTROINTESTINAL

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Ileostomy |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Gastroesophageal Reflux Disorder (GRD) | <input type="checkbox"/> Mouth Disorders (tooth decay, fungal infection) |
| <input type="checkbox"/> Dehydration | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Ulcers |

Comments :

MUSCULOSKELETAL

- | | | |
|---|---|--|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Fractures | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Arthritis (osteo/rheumatoid) | <input type="checkbox"/> Lifting/Bending Restrictions | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Contractures | <input type="checkbox"/> NWB | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Total Hip Replacement |

Comments :

NEUROLOGICAL

- | | | |
|---|--|---|
| <input type="checkbox"/> Alzheimer's or other Dementia
_____ | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Aphasia | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Quadriplegia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Slurred Speech |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Headaches | <input type="checkbox"/> TIA |

Comments :

Client: _____

GENITOURINARY

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> BPH | <input type="checkbox"/> Nocturia |
| <input type="checkbox"/> Catheter | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Stones |
| <input type="checkbox"/> Frequency | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Other _____ | |

Comments :

SKIN

- | | |
|--|---|
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Decubitus ulcers | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Venous Stasis Ulcers |
| <input type="checkbox"/> Foot Condition (bunions, corns, calluses) | <input type="checkbox"/> Wounds |
| <input type="checkbox"/> Other _____ | |

Comments :

PSYCHOSOCIAL

Marital Status Married Widowed Divorced Single

- | | |
|--|--|
| <input type="checkbox"/> Appropriate Use of Drugs, Alcohol | <input type="checkbox"/> Other Family/Support Lives in Home
_____ |
| <input type="checkbox"/> Drives | <input type="checkbox"/> Reads |
| <input type="checkbox"/> Extended Family/Friends | <input type="checkbox"/> Smokes |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Tells Time |
| <input type="checkbox"/> Manages money | <input type="checkbox"/> Understands Verbal/Written Communication |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Writes |

Cultural, spiritual or other beliefs or practices that may affect care } _____

Years of education completed: _____ yrs. Former occupation: _____

Comments:

Client: _____

REPRODUCTIVE **Breast Cancer** **Prostate Cancer** **Other** _____ **Uterine Cancer****Comments :**

Client: _____

PAIN ASSESSMENT...

In instances in which the client has cognitive impairment, hearing impairment or limited attention span nurse may need to repeat instructions/questions. Make sure to allow adequate time for a response. Include the family/caregiver.

- Client experiences pain, discomfort, aching

Location of pain _____

Pain is...	Frequency...
<input type="checkbox"/> Steady	<input type="checkbox"/> Daily
<input type="checkbox"/> Intermittent	<input type="checkbox"/> Less than daily
<input type="checkbox"/> Momentary	<input type="checkbox"/> At all times

- ✓ When did pain begin?- _____
- ✓ How long does pain last? _____
- ✓ Any accompanying symptoms associated with the pain?(i.e, nausea, headache) _____

✓ Any recent changes in client's activities, functional status or behavior? _____

✓ Describe the pain (pain characteristics):

- | | | |
|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Pinching | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Pounding | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Pressure | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Radiating | <input type="checkbox"/> Other |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Sharp | |

✓ What is the client doing currently to relieve the pain?

- | | |
|---|--|
| <input type="checkbox"/> Audio or video tapes | <input type="checkbox"/> Relaxation |
| <input type="checkbox"/> Back rubs | <input type="checkbox"/> TENS |
| <input type="checkbox"/> Imagery | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Other diversionary activity |
| <input type="checkbox"/> Medication | |

Are these methods working? Yes No

Is client taking any pain medications? Yes No

Does client have medication order? Yes No

If YES above, describe medication(s); include over-the-counter medications and herbal remedies:

NAME	DOSAGE	FREQUENCY	SIDE EFFECTS

Client: _____

How do the following affect the pain?

	INCREASES	DECREASES	NO EFFECT
Sleep/rest			
Lying down			
Movement (position change, ambulation)			
No movement			
Weather changes			
Heat			
Cold			
Mild exercise			
Distraction (TV, reading, etc.)			
Bright lights			
Loud noise			
Other			

Which of the following does the pain affect in the client's life? Check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Ability to take medication | <input type="checkbox"/> Cooking | <input type="checkbox"/> Transfer/toileting |
| <input type="checkbox"/> Ability to use telephone | <input type="checkbox"/> Dressing | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Ability to use transportation | <input type="checkbox"/> Eating/appetite | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Ambulation | <input type="checkbox"/> Hygiene/grooming | <input type="checkbox"/> Social activities |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Laundry | |

Does the client have any of the following illnesses/conditions that may be associated with pain? Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Old fractures |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Post amputation |
| <input type="checkbox"/> Diabetic neuropathy | <input type="checkbox"/> Post herpetic neuralgia |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Spinal stenosis |
| <input type="checkbox"/> Ischemia | <input type="checkbox"/> Tension headaches |
| <input type="checkbox"/> Mechanical deformities | <input type="checkbox"/> Trauma/surgery |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Trigeminal neuralgia |
| | <input type="checkbox"/> Wounds |

What are the client's beliefs and attitudes regarding pain:

- ✓ Does client feel it is normal to have pain? Yes No
- ✓ Does the client feel that all pain should be treated? Yes No
- ✓ Any cultural or religious beliefs that would influence the management of pain? Yes No
 - If yes, explain _____

Client: _____

What is the client's/family's goal for pain management?

- Decreased pain
- Improved sleep
- Improved mobility
- Other _____

NOTE TO ASSESSOR/NURSE AND AIDE...

PAIN IS NOT ALWAYS EXPRESSED VERBALLY. Therefore, it is important to watch for typical signs of those experiencing acute/chronic pain. These include anxiety, sweating, apprehension, decreased concentration, restlessness, crying, moaning, grimacing, furrowed brow, clenched fists or teeth, lying rigidly in bed, an increase in blood pressure, pulse and respiration, an inability to sleep, sleeping a great deal, irritability, depression, fatigue, withdrawn, combativeness, confusion, rubbing at painful areas, quiet, stoic, resisting movement (such as turning, moving or ambulation).

For COGNITIVELY IMPAIRED CLIENTS...

- ✓ *Observe facial expressions, verbalizations, vocalizations, body movement*
- ✓ *Ask family member(s)/caregivers about changes in interpersonal interactions, changes in activity or routine, changes in mental status*
- ✓ *Some behaviors that may indicate pain in the cognitively impaired client include grimacing, rapid eye blinking, tears, a sad face, closed or tightened eyes, moaning or groaning, grunting, calling out, increased rocking, increased wandering, pacing, refusal to eat or an appetite change, sleep disturbances.*
- ✓ Any nonverbal expressions of pain? Yes No

If Yes, explain: _____

- Maintain "pain log or diary":
 - Log is to be maintained by:
 - CHHA
 - Family member
 - Other caregiver

Client: _____

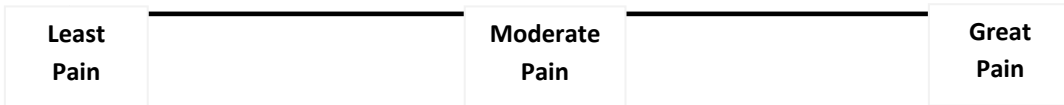
PAIN ASSESSMENT (cont'd)...

PAIN SCALES—select, as appropriate for client

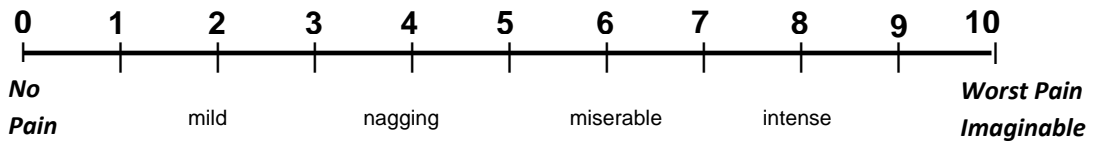
Categorical Scale

None (0) Mild (1-3) Moderate (4-6) Severe (7-10)

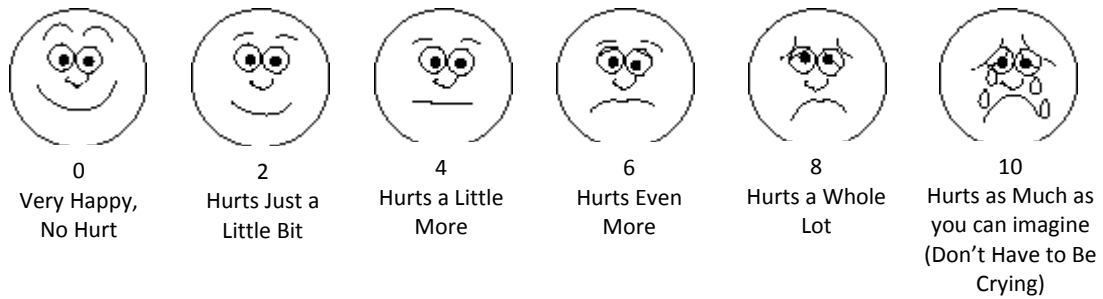
Visual Scale



Numerical Scale



Pain Faces Scale



COMMENTS:

Client: _____

PRESSURE SORE RISK ASSESSMENT

BRADEN RISK ASSESSMENT SCALE

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SENSORY/ MENTAL	MOISTURE	ACTIVITY	MOBILITY	NUTRITION	FRICION/SHEAR
Completely limited 1	Constantly moist 1	Bedfast 1	Completely immobile 1	Very poor 1	Problem 1
Very limited 2	Often moist 2	Chairfast 2	Very limited 2	Probably inadequate 2	Potential problem 2
Slightly limited 3	Occasionally moist 3	Walks occasionally 3	Slightly limited 3	Adequate 3	No apparent problem 3
No impairment 4	Rarely moist 4	Walks frequently 4	No limitation 4	Excellent 4	
TOTAL BRADEN SCORE: <input style="width: 50px; height: 20px;" type="text"/>					
(16 or less...if Under age 65, AT RISK; 18 or less...if 65 or over, AT RISK)					

Client: _____

FALL RISK ASSESSMENT...

Does client present with acute/recent fall?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does client have a history of past falls?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES...	Number of falls		
	Fallen in past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Last time fell		
	Describe how and why fall occurred		
	What was the result of the fall?	<input type="checkbox"/> Injury _____ <input type="checkbox"/> Hospitalization _____ <input type="checkbox"/> None	

Gait/Balance

If possible, have the client sit in a hard, armless chair. Ask client to stand. Observe, while answering questions below. Ask client to walk a short distance; observe while answering questions below. Ask client to sit; observe while answering questions below.

PLEASE ENSURE THE CLIENT'S SAFETY WHEN ADMINSTERING THESE TESTS. PERFORM ONLY IF SAFE FOR THE CLIENT. IF UNABLE TO ASSESS, CHECK THE APPLICABLE BOX.

Does client slide/lean in chair?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
Is client unable to stand without help?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
Does client use arms to help stand?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
Does client require more than one attempt to rise?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
When standing, is client's stance narrow?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
Is standing balance steady without use of an assistive device?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
Can client stand steady with eyes closed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS

Client: _____

Can client walk without hesitating?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
Does each foot clear the floor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
When client walks a short distance and comes to a complete stop...	<input type="checkbox"/> STEADY?		<input type="checkbox"/> UNSTEADY?
When client turns around and returns to chair...	<input type="checkbox"/> STEADY?		<input type="checkbox"/> UNSTEADY?
Can client sit down without using arms to help?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS
Is client able to judge distance correctly when sitting?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> COULD NOT ASSESS

<u><i>Gait/Balance Assessment</i></u>	<input type="checkbox"/> IMPAIRED BALANCE	<input type="checkbox"/> IMPAIRED GAIT	<input type="checkbox"/> COULD NOT ASSESS
---------------------------------------	--	---	--

Vision

<i>Any reported problems?</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glasses
		<input type="checkbox"/> Blind

<i>Date of last eye exam?</i>	_____
-------------------------------	-------

Hearing

	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>Any reported problems?</i>	<input type="checkbox"/> Hearing aids	<input type="checkbox"/> Deafness
	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Other

Client: _____

Elimination

Any problems with...	<input type="checkbox"/> Incontinent bowel/bladder	<input type="checkbox"/> Urinary frequency	<input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Nocturia	<input type="checkbox"/> Urinary Urgency	
Does client use diuretics?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does client use laxatives?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History
Relevant to Risk of Falls

Any acute/chronic problems that may affect functional ability (i.e., ROM, ambulation)?	<input type="checkbox"/> Amputee	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cast
	<input type="checkbox"/> Contractures	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fractures
	<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Parkinson's
	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Spinal stenosis	
Any history of...	<input type="checkbox"/> Angina	<input type="checkbox"/> Arrhythmias	<input type="checkbox"/> Cardiomyopathy
	<input type="checkbox"/> CHF	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> CVA
	<input type="checkbox"/> HTN	<input type="checkbox"/> MI	
Any complaints about or history of...	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Dizziness upon standing	<input type="checkbox"/> Fainting
	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Palpitations
	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Weakness	
Is there a fear of falling?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Does client use assistive devices?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Prosthesis
	<input type="checkbox"/> Scooter	<input type="checkbox"/> Splints, braces	<input type="checkbox"/> Walker
	<input type="checkbox"/> Wheelchair		

Client: _____

Foot Issues

Type of footwear	<input type="checkbox"/> Barefoot	<input type="checkbox"/> Non-skid socks	<input type="checkbox"/> Slippers
	<input type="checkbox"/> Sturdy, rubber-soled shoes	<input type="checkbox"/> Walking shoes	
Any history of foot problems?	<input type="checkbox"/> YES	<input type="checkbox"/> No	
	<input type="checkbox"/> Bunions	<input type="checkbox"/> Calluses	<input type="checkbox"/> Corns
	<input type="checkbox"/> Pain	<input type="checkbox"/> Toe deformities	<input type="checkbox"/> Other _____

Contributing Issues

Any cognitive impairment? (Refer to Mental Assessment)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any environmental hazards? (Refer to Safety Checklist)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with pain management or pain management consultation? (Refer to pain Assessment)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Medications

Does the client take 4 or more medications?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Does the client take any of these medications?	<input type="checkbox"/> Antianxiety	<input type="checkbox"/> Anticonvulsants	<input type="checkbox"/> Muscle relaxants
	<input type="checkbox"/> Psychotropics	<input type="checkbox"/> Sedatives	<input type="checkbox"/> Sleep medication (hypnotics)

Physical Examinations

Date of last physical exam _____	Date of next scheduled physical exam _____
--	--

Client: _____

SAFETY CHECKLIST...

CATEGORY	ITEM		COMMENTS
LIGHTING	Is there adequate lighting throughout the house?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are all hallways, stairwells, passageways and other areas traveled after dark well-lit or have night lights?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are burned out bulbs replaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are light switches located at top and bottom of stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ELECTRICAL	Are electrical cords free from fraying/cracking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do cords run along the wall? Are any under carpeting/rugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are appliances in good working condition and protected from or exposed to moisture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are outlets overloaded?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do plugs fit snugly into sockets?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
KITCHEN	Is there a fire extinguisher in kitchen for grease fire?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is stove/oven clean and free of grease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is area well-lit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are knives/sharp objects in secure areas and out of the reach of children/confused individuals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there any safety devices on stove/oven? Particularly important for those with dementia/confusion.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there any scatter rugs or unsafe/slippery floor surfaces?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Client: _____

CATEGORY	ITEM		COMMENTS
BATHROOM	Are there grab bars in the shower and tub?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there non-skid mats inside/outside shower and tub?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there grab bars by sink and toilet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is there a shower chair/bench?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is there a raised toilet seat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Any scatter rugs? Do they have a non-skid backing? Are there unsafe or slippery floors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is the water heater adjusted to less than 120 degrees?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are hot and cold faucets correctly marked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is there adequate lighting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is there a light switch located inside/outside the bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
BEDROOM/SLEEPING AREA	Check height of client's bed. Can they get in and out safely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is there a telephone and/or call bell near the bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is there a night-light or light switch within reach?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Any scatter rugs? Are there unsafe or slippery floors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is there adequate lighting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Client: _____

CATEGORY	ITEM		COMMENTS
MEDICATIONS	Are medications stored in secure areas—out of the reach of children and those with dementia/confused?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are medications in the original container and clearly labeled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are they expired?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
FIRE	Are there smoke alarms in hallways, kitchen, bedroom, attic, and basement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are all smoke alarms working?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are exits available from all locations in the house?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is there a fire plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If there is a fireplace, is there a smoke screen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are all curtains/flammable items away from the stove?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
MISCELLANEOUS	Is temperature in client's environment too hot or cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is emergency information posted on or near the telephone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are pathway, stairs, etc. free of clutter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there hand rails on stairs indoors/outdoors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there ramps?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are there proper locks on doors for those with dementia/forgetfulness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are sidewalks in need of repair?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are frequently used items stored in an easily accessible place—without the need for a stool/chair?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are cleaning substances, poisons, etc. stored in secure area—out of the reach of children and those with dementia/confusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Client: _____

PART THREE—Plan of Care

Client: _____

CLIENT'S SPECIAL NEEDS

- T,P,R and Weights—Complete “T, P, R and Weight Record”, GN-08-TPR
- Pain—Maintain “Pain Log/Diary”, GN-08-PL
- Oxygen (see Special Instructions)
- Fall prevention (precautions)
- Diabetic care and monitoring (see Special Instructions)
- Non-sterile dressings
- Minor wound care
- Foley catheter care (see Special Instructions)
- Decubiti prevention (see Special Instructions)
- Pacemaker (see Special Instructions)
- Seizure precautions (see Special Instructions)
- Amputee
- I&O-Maintain “Intake & Output Record”, GN-08-IOR”
- Bleeding precautions (see Special Instructions)
- Behavior monitoring-Maintain “Behavior Monitoring Record”, GN-08-BMR
- Other _____

GENERAL PHYSICAL LIMITATIONS...

- Legally blind
- Vision impaired
- Wears glasses
- Cataracts
- Deaf
- Hard of hearing*
- Hearing aid ____R ____L
- Clear speech
- Slurred speech
- Unintelligible
- Dentures ____Upper ____Lower

**If client is hard of hearing be certain to speak slowly and look directly at her/him when speaking*

INFECTION CONTROL....

Aide is to take these precautions:

- Standard precautions
Hand hygiene, gloves, gowns and masks, respiratory hygiene, cough etiquette, care of equipment/environment, safe handling of needles and syringes
- Contact precautions
- Droplet
- Airborne
- Other _____

MEDICATIONS...

- Family dispenses medications
- Family/other authorized person fills medication dispenser
- Client/family aware of possible side effects, purpose, dose, etc.
- Provide medication reminder ONLY*
**Under no circumstance should the Aide handle, manage or dispense medication. If client refuses medication, notify the office immediately at (908)769-0800.*

Medication Allergies:

Client: _____

ACTIVITY...

- Fall risk (see assessment)
- Oxygen (see special instructions)
- Bed rest
- Turning schedule

Special equipment:

- Foot rolls
- Sheepskin
- Heel/elbow protectors
- Other
- Special stockings

- Bed side rails*
- Padded side rails*
- Call bell*
- Phone at bedside*
- Bed alarm*
- Elevate head of bed*
- Other* _____

Bed type _____ Mattress type _____

Bedtime Routine:

--

AMBULATION...

- Client is independent
- Client requires assistance
- Client is non-ambulatory

Reason _____

- Contact guarding
- Safety supervision

- Gait belt
- Walker
- Cane

- Dangle prior to ambulating

Times/day _____

- Restrictions
- Reasons _____

- Wanders
- Door alarms/locks

- PT Evaluation
- PT Evaluation recommended**

- Exercise: Range of Motion
- Exercise: Other

TRANSFERS...

- Out-of-bed to wheelchair
- Client is independent
- Hoyer
- Pivot
- Dangle prior to out-of-bed

Special equipment:

- Cushions
- Lift chair
- Ramp
- Other _____

- Out-of-bed to chair
- Client requires assistance
- Slide board
- Elevate legs
- Other _____

- Chair alarm
- Transfer belt

- Stair lift
- Stair banister

Client: _____

NUTRITION...

Height _____ ft. _____ in.

Weight _____ lbs.

Food Allergies

Food Likes

Food Dislikes

Appetite description _____

- Weight gain
- Weight loss
- Difficulty chewing
- Difficulty swallowing
- ST evaluation
- Thicken liquids _____
- Supplements _____
- Meals-on-Wheels; *when?* _____

Diet type:

- Regular
- Soft (mechanical)
- Bland
- Diabetic
- Renal
- Kosher
- Vegetarian
- Lactose intolerant
- Low cholesterol
- Low fat
- Low sodium
- No sodium
- High fiber
- Low fiber
- Clear liquids
- Full liquids
- Soft
- Other _____

- Client feeds independently
- Client requires assistance feeding
- Client requires total assistance feeding
- Prepare food
- Serve food
- Snacks

- Encourage fluids
- Restrict fluids _____ cc/day
- I&O-Maintain "Intake & Output Record", GN-08-IOR"
- Maintain "Daily Food Log", GN-08-DFL
- Adaptive equipment
- Weigh client—Use "T, P, R Weight RECORD", GN-08-TPR
- Other _____

ELIMINATION...

- Incontinent bowel
- Constipation
- Bowel routine _____

- Laxative use
- Record bowel movements
- Colostomy
- Ileostomy

- Use of adult diaper
- Incontinent care after each episode
- Client toilets independently
- Client requires assistance with toileting
- Toileting schedule: _____

- Incontinent bladder
- Frequency
- Urgency
- Voiding at night
- History of urinary tract infections (UTIs)
- Bladder routine _____

- Record urine output; use "Intake & Output Record", GN-08-IOR
- Bedpan
- Commode
- Bathroom

Client: _____

ELIMINATION (cont'd)

Foley catheter (See Special Instructions)

- Empty Foley catheter
- Leg bag out-of-bed

- Monitor/record I&O use "Intake & Output Record", GN-08-IOR
- Observe and monitor signs and symptoms of UTI
- Other _____

BATHING...

- Client requires total support
- Client requires assistance
- Client bathes independently
- Shower
- Bed bath

Equipment:

- Non-skid mat
- Shower chair
- Shower bench
- Grab bars
- Hand-held shower
- Other _____

ALWAYS CHECK BATH/SHOWER WATER TEMPERATURE!

DRESSING...

- Client requires total support
- Client requires assistance
- Client dresses independently

By occupational therapist
Details. _____

Adaptive equipment
Details. _____

HAIR CARE...

- Beauty parlor
- Shampoo, _____ X per week
- Other

NAIL & FOOT CARE...

- ✓ By Client, no assistance
- ✓ By family
- ✓ By podiatrist _____
- ✓ Diabetic care
- ✓ By salon
- ✓ File/clean nails

Aide should NOT clip nails

Client: _____

<p><u>ORAL HYGIENE...</u></p> <p><input type="checkbox"/> Client requires total support</p> <p><input type="checkbox"/> Client requires assistance</p> <p><input type="checkbox"/> Client independent</p> <p><input type="checkbox"/> Brush teeth</p> <p>Type of toothbrush (e.g., soft bristle)</p> <p>_____</p> <p>—</p> <p><input type="checkbox"/> No flossing</p> <p><input type="checkbox"/> Denture care</p> <p><input type="checkbox"/> Regularly uses mouthwash/gargle</p> <p><input type="checkbox"/> Swabs mouth</p> <p><input type="checkbox"/> Other</p> <p>_____</p>	<p><u>SHAVING...</u></p> <p><input type="checkbox"/> Shave (<u>electric razor only</u>)</p> <p><i>NEVER use any electrical device while oxygen is in use or running; see Oxygen Safety and Precautions instructions</i></p>
	<p><u>SKIN CARE...</u></p> <p><input type="checkbox"/> Lotion _____</p> <p><input type="checkbox"/> Powder _____</p> <p><input type="checkbox"/> Barrier creams/ointments (e.g., A&D)</p> <p>_____</p>

SOCIALIZATION...

Client's Hobbies and Interests	

<p><input type="checkbox"/> Accompany to appointments/visits*</p> <p><input type="checkbox"/> Mental exercises/games</p> <p><input type="checkbox"/> Play music</p> <p><input type="checkbox"/> Reminiscing</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Board games/card games</p> <p><input type="checkbox"/> Grocery/other shopping*</p> <p><input type="checkbox"/> Outings/drives*</p> <p><input type="checkbox"/> Read aloud</p> <p><input type="checkbox"/> Watch television</p>
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***Aide may not use or own or Client's vehicle without express prior review and approval by Generations' management of insurance and satisfactory Department of Motor Vehicle review**

Client: _____

LIGHT HOUSEKEEPING...

- Family cleans house
- Housekeeping service

Frequency: _____ Days: _____

- Clean and straighten Client's bedroom
- Clean kitchen, wash dishes
- Clean and straighten areas of house used by Client
- Do Client's personal laundry
- Remove trash
- Other: _____

- Clean and straighten Client's bathroom
- Change bed linens
- Floor care areas used by Client
- Water plants
- Care for equipment
- Feed dog, cat, other pet. Must have specific instructions from Client...

Client: _____

PART FOUR—Assessment Participants

Client: _____

INFORMATION TO COMPLETE THIS ASSESSMENT FORM WAS PROVIDED BY...

<i>Source</i>	<i>Details (names, specific records relied upon, etc.)</i>
<input type="checkbox"/> Client	
<input type="checkbox"/> Family member	
<input type="checkbox"/> Clinical records/transfer forms	
<input type="checkbox"/> Other professionals involved in client care	
<input type="checkbox"/> Other	

PERSONS PRESENT AT ASSESSMENT...

<i>Person Present</i>	<i>Name(s)</i>
<input type="checkbox"/> Client	
<input type="checkbox"/> Family member	
<input type="checkbox"/> Neighbor	
<input type="checkbox"/> Other	

Initial assessment

Reassessment (Date of Initial Assessment _____)

By: _____ Date: _____