

Nursing Assessment for Home Care

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____
 ADAP ID Number: **555-**_____ Social Security Number: _____
 Contact Person (Name & Relationship): _____
 Contact Phone (Day-time): _____ **Please submit release to allow Program contact.**

Living Situation:

Dwelling: Apartment House Other: _____ Floor: _____ # of Rooms: _____ Elevator: Yes No
 Lives alone: Yes No Identify all individuals living in the home: _____
 List the services, hours and days they are available and able to assist with care giving: _____

Hospitalization:

Hospital Name: _____ Address: _____
 Hospitalized: From: _____ To: _____ Diagnoses: _____
 Hospital Contact: _____ Phone: _____

Patient Status:

Is patient alert? Always Sometimes Never
 Can patient direct a home care worker? Yes No
If no, who is responsible for directing home care workers?
 Name/Relationship: _____
 Patient Height: _____ Patient Weight: _____
 Recent significant weight loss? Yes No If Yes, amount lost: _____

Impairments:

Sensory:

	None	Partial	Total
1. Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Sight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Muscular/Motor:

	None	Partial	Total
1. Hand/Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular / Respiratory:

	None	Partial	Total	Describe impact on functional ability.
1. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

1. Does patient have history of tuberculosis? Yes No Pulmonary Extra pulmonary
 2. Did patient complete therapy? Yes No
 3. Does patient currently have tuberculosis? Yes No Pulmonary Extra pulmonary
 4. Is patient currently on tuberculosis prophylaxis? Yes No Hx of TB prophylaxis Yes No
 5. Last documented PPD: Date and result _____ Anergy results if available: _____
 6. If on tuberculosis treatment, are there 3 negative AFB? Yes No Negative chest x-ray Yes No

Patient Name: _____ ADAP ID#: 555- _____
 Agency: _____ Provider Number: _____

Mental Status			Never	Partial	Total	Never	Partial	Total
1. Oriented place and time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Danger to: Others (Aggressive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Agitated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Articulates needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Short term memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Abusive to: Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Impaired judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Other Cognitive / Mental Status Information:				

Patient Ability to Take/Administer Medication:

	Never	Sometimes*	Always	*Complete #7.
1. Totally independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Needs reminding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Non-compliant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Needs help preparing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Needs administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Patient/care giver can be taught to administer				<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Please explain: _____				

If patient is not independent, what arrangements have been made to administer medications?

IV Infusion and Injections: **# of Times Per Week**
 Patient requires home infusion via: _____
 Central Line Peripheral Line
 Injections _____
 Blood work (in the home) _____

Elimination:

	Bowel	Bladder
Continent	<input type="checkbox"/>	<input type="checkbox"/>
Occasionally Incontinent	<input type="checkbox"/>	<input type="checkbox"/>
Incontinent	<input type="checkbox"/>	<input type="checkbox"/>

Medical Treatment: (Check ✓ all that apply) Please list all medications on AI485:

1. Decubitus care	<input type="checkbox"/>	6. Monitor vital signs	<input type="checkbox"/>	11. Blood tests	<input type="checkbox"/>
2. Dressings - Simple	<input type="checkbox"/>	7. Tube feeding	<input type="checkbox"/>	12. Ambulation exercise	<input type="checkbox"/>
3. Dressings - Sterile	<input type="checkbox"/>	8. Tube irrigation	<input type="checkbox"/>	13. Rehabilitative therapy	<input type="checkbox"/>
4. Enema	<input type="checkbox"/>	9. Suctioning	<input type="checkbox"/>	14. Physical therapy	<input type="checkbox"/>
5. Catheter care	<input type="checkbox"/>	10. Oxygen administration	<input type="checkbox"/>		

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Identification of Service Needs:

	Without Help	With Cane	With Walker	With Wheelchair	With Personal Assistance	Unable
Ambulate inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulate outside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get up from seated position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get up from bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer to:						
Commode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indicate Patient's Personal Service Needs:

	Independent	Partial Assist	Total Assist		Independent	Partial Assist	Total Assist
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toileting/ Bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinal or bedpan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Commode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reheat Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housecleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the patient homebound? Yes No*

*If patient is not homebound, you must submit justification of home care separately.

Certification:

This assessment is based on personal observation of the patient. Yes No

This assessment is based on information relayed to me by: _____

Prepared by: (print name) _____ Phone #: _____

Agency Affiliation: _____ FAX#: _____

Signature: _____ Date: _____

Is any other agency/vendor providing services in the home to the patient? Yes No

If Yes, Agency Name: _____ Services: _____

Have all home care insurance benefits been exhausted? Yes No

Is this patient eligible for Medicaid? Yes No Have they applied to Medicaid? Yes No

If No, state reasons: _____

FOR NEW HOME CARE APPLICANT ONLY:

How was the applicant referred to your agency?

- Doctor Social Worker Discharge Planner Location: _____
 Other Please explain: _____