DSHS
WASHINGTON STATE Department of Social and Health Services

Date of Review	☐ Annual ☐ Initial ☐ Six (6) Month
Date of Last Review	

PRISM Scores
Current PRISM Score:
Previous PRISM Score:
Admit Risk Score:
Previous Admit Risk Score:
TPL / MCO:

Developmental Disabilities Community Services (DDCS)

Nursing Care Consultant Assessment

Client Demographic Information

Client's Name	Gender ☐ Male ☐ Female ☐ Other:	Age	Date of Birth	ADSA Number

Address

Parent / Guardian's Name	Telephone Number

Individuals Present for Assessment

Family / Informal Support

Nurse / Nursing Agency / Agencies	Current Nursing Hours	Telephone Number(s)

Clinical Supervisor	Telephone Number

Case Resource Manager	Telephone Number

Personal Care Hours	Respite Hours	Personal Care Provider

Provider	Specialty	Last Visit	Outcome

Code Status

Diagnosis

Allergies

Weight	Height	Vaccinations: Influenza? ☐ Yes ☐ No Pneumococcal? ☐ Yes ☐ No Comments below:

Laboratory Work

Initials _____ Date_____

911 / ED Visits / Hospitalizations / Illnesses

Upcoming Surgeries / Procedures

Medications

Updates / changes:

Communication

Verbal communication:

Method(s) of communication:

Ability to express wants / needs:

Ability to ask for help in the event of an emergency:

Comments:

Community Inclusion

School name and schedule:

Activities / interests:

Comments:

Musculoskeletal

Musculoskeletal limitation:

Mobility:

Equipment used:

Equipment needed:

OT? ☐ Yes ☐ No PT? ☐ Yes ☐ No SLP? ☐ Yes ☐ No PROM? ☐ Yes ☐ No

Comments:

Respiratory

Vented: ☐ Yes ☐ No

Vent schedule:

Initials _____ Date_____

Trach: ☐ Yes ☐ No. If yes, reason:

Trach change frequency:

Who does the trach change:

Trach care frequency:

Trach suctioning frequency:

Oral suctioning frequency:

Nasal suctioning frequency:

Requires oxygen: ☐ Yes ☐ No

Oximeter frequency:

Passy Muir Valve (PMV) use / tolerance:

Heated Moisture Exchange: ☐ Yes ☐ No

Capping use / tolerance:

Nebulizer:

Cough assist:

Respiratory vest / manual CPT:

CPAP / BIPAP:

Resuscitation within the last year: ☐ Yes ☐ No

Comments:

Genitourinary / Gastrointestinal

Diet:

Initials _____ Date_____

Oral feeder: ☐ Yes ☐ No

JT: ☐ Yes ☐ No

GT: ☐ Yes ☐ No

Who does the tube change:

Stoma care frequency:

Tube feeding schedule and rate:

Venting schedule:

Farrell bag:

Measurement of I & O:

Continent of bowel: ☐ Yes ☐ No

Bowel program: ☐ Yes ☐ No

Continent of bladder: ☐ Yes ☐ No

Use of catheter: ☐ Yes ☐ No

Menstrual cycle:

Comments:

Neurology

History of seizures / type / frequency / intervention:

Pain type / location / relieved by:

Comments:

Cardiac

Endocrinology

Vascular

Central lines: ☐ Yes ☐ No
Comments:

Integumentary

Skin integrity / pressure injuries:

History of pressure injuries:

Skin Observation Protocol triggered: ☐ Yes ☐ No
Date: Who was SOP referred to:

Wound care:

Comments:

Emergency Preparedness

Correct size of AMBU bag for resuscitation (what size): ☐ Yes ☐ No
Neonatal: ☐ Yes ☐ No
Pediatric: ☐ Yes ☐ No
Adult: ☐ Yes ☐ No

Emergency To Go Bag: ☐ Yes ☐ No
Back-up ventilator / concentrator: ☐ Yes ☐ No ☐ N/A
Back-up batteries: ☐ Yes ☐ No ☐ N/A
Generator: ☐ Yes ☐ No

Are you connected with local police / fire departments / Smart 911: ☐ Yes ☐ No Comments:

Client Observation at Time of Visit

Issues / Concerns

NCC Recommendations

Clinical Criteria Tool Score

Recommendations

The information in this document, from my observations, is true and accurate. The information in this document, as reported to me, is accurately recorded.

Signature	Date	Title	Initials