Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Nursing Care Consultant Assessment

DATE OF VISIT	
TIME OF VISIT	FROM ☐ AM ☐ PM TO ☐ AM ☐ PM

I. Client Demographic Information

CLIENT'S NAME	SEX ☐ Male ☐ Female	AGE	DATE OF BIRTH
ADDRESS			TELEPHONE NUMBER
LOCATION OF VISIT			
CAREGIVER / PROVIDER'S NAME			TELEPHONE NUMBER
Caregiver / provider was present for this visit: ☐ Yes ☐ No; how long has he/she worked with this client?			
NAME OF CONTACT PERSON FOR CLIENT	RELATIONSHIP		TELEPHONE NUMBER
Contact person was present for this visit: ☐ Yes ☐ No			
GUARDIAN'S NAME (IF APPLICABLE)			TELEPHONE NUMBER
CASE RESOURCE MANAGER			TELEPHONE NUMBER

II. Client Physical Assessment

DIAGNOSES	ALLERGIES

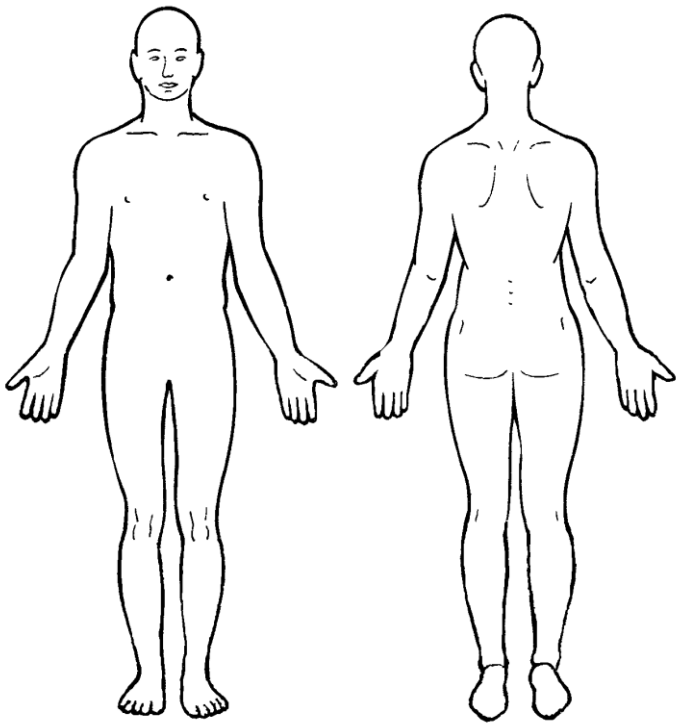
WEIGHT ☐ Reported ☐ Actual	HEIGHT ☐ Reported ☐ Actual	BLOOD PRESSURE	TEMPERATURE	PULSE	RESPIRATIONS

	WITHIN NORMAL LIMITS	ABNORMAL	SPECIFY PROBLEM
EENT	☐	☐	
Level of Consciousness	☐	☐	
Pupils	☐	☐	
Respiration/lung sounds	☐	☐	
Bowel sounds	☐	☐	
Abdomen	☐	☐	
Musculoskeletal / contractures / deformities	☐	☐	
Cardiovascular	☐	☐	
Skin integrity (if problem, see page two)	☐	☐	

LAST HISTORY AND PHYSICAL EXAM

PHYSICIAN ORDERS FOR DIET, MEDICATIONS, AND TREATMENTS

OTHER PERTINENT MEDICAL INFORMATION



BODY CHECK DIAGRAM

Sketch skin irregularities on front and/or back of body and number them (#1, #2, etc.).

Use the SKIN ASSESSMENT chart below to describe the skin irregularity. **Add additional sheet(s), if necessary.**

Types:

- Discoloration/redness
- Blister
- Bruise
- Rash
- Lesion/laceration
- Ulcer (pressure or stasis)
- Incision with staples or sutures
- Incision with steri strips
- Dressings or dressing changes
- Trauma wound
- Burn
- Other (describe)

SKIN ASSESSMENT

SKIN IRREGULARITY NUMBER AND LOCATION	SKIN IRREGULARITY TYPE	TREATMENT PLAN IN PLACE? DESCRIBE.
1.		
2.		
3.		

4.		

SKIN RISK FACTORS

	YES	NO
Current Pressure Ulcer	☐	☐
Quadriplegia (paralysis of all 4 extremities)	☐	☐
Paraplegia (paralysis of lower body)	☐	☐
Total Dependence in Bed Mobility (must be positioned)	☐	☐
Comatose or Persistent Vegetative State	☐	☐
History of Pressure Ulcer Within One Year	☐	☐
Bedfast and/or Chairfast*, and Cognition (thought) Problems	☐	☐
Bedfast and/or Chairfast*, and Incontinent of Bladder or Bowel)	☐	☐

	YES	NO
Hemiplegia (paralysis on one side of the body), and Cognition (thought) Problems, and Incontinent of Bladder or Bowel.	☐	☐
Bedfast and/or Chairfast*, and Diabetes	☐	☐
Altered Nutrition (decreased intake protein, fluids etc)	☐	☐
Spasticity and/or Involuntary Movements	☐	☐
Independent Movement Altered (due to physical or cognitive reasons)	☐	☐
Decreased Sensation (not only from paralysis as outlined above)	☐	☐

* Bedfast and/or chairfast: Individual is in bed, wheelchair or recliner for 22 hours or more per day.

NUTRITIONAL STATUS

DIET

TOLERANCE OF DIET

Food intake adequate? ☐ Yes ☐ No; if not, why:

Fluid intake adequate? ☐ Yes ☐ No; If not why?

Is Intake and Output monitoring needed? ☐ Yes ☐ No

Who assures that diet is followed? _____

Who assures that appropriate and needed nutritional items are stocked and ready for use? _____

Does client appear well nourished? ☐ Yes ☐ No Overweight? ☐ Yes ☐ No Underweight? ☐ Yes ☐ No

CRITERIA	YES	NO	SPECIFY PROBLEMS/COMMENTS/FOLLOW-UP NEEDED
1. Does client have illness or condition that re quires a change in the kind or amount of food eaten?	☐	☐	
2. Tooth or mouth problems which cause difficulty eating?	☐	☐	
3. Problems chewing foods?	☐	☐	
4. Problems drinking liquids?	☐	☐	
5. Special diet? Is it followed?	☐	☐	
6. Feed self? Type of assistance needed, if any?	☐	☐	
7. Cough/choke frequently when eating?	☐	☐	
8. Dysphagia/swallowing problem?	☐	☐	

9. Eats fruits, vegetables, milk products?	☐	☐	
10. Consume alcohol? If yes, how much?	☐	☐	
11. Have resources to purchase needed food?	☐	☐	
12. Cooks for self? Adequately?	☐	☐	
13. Pneumonias or frequent respiratory problems?	☐	☐	
14. Reflux? If yes, is head of bed raised?	☐	☐	
15. Takes three or more medications per day (excluding vitamins)?	☐	☐	
16. Unintentionally lost or gained more than 10 pounds in the past six months?	☐	☐	
17. Being weighed regularly and frequently enough?	☐	☐	
18. Significant memory loss? Depression?	☐	☐	
19. Enjoy food and eating?	☐	☐	
20. How much (i.e. ¼, ½, ¾, entire meal) of the meal does client eat?	☐	☐	
21. Receive nutritional supplements? If "yes", what and how often?	☐	☐	
22. Tube fed? If "yes", specify formula. Tolerance?	☐	☐	

MOBILITY/MOVEMENT/TRANSFERS/ACTIVITY LEVEL

DESCRIBE

POSITIONING IN BED, WHEELCHAIR, AND/OR OTHER

1. Does client need assistance to reposition in bed? ☐ Yes ☐ No
   Wheelchair? ☐ Yes ☐ No
   Other? ☐ Yes ☐ No; If yes, what:

2. How often is client repositioned (in bed, wheelchair, etc.)?

3. Is there a repositioning schedule? ☐ Yes ☐ No If yes, describe:

4. Is client comfortable in bed? ☐ Yes ☐ No If no, specify:

5. Is client comfortable in wheelchair? ☐ Yes ☐ No If no, specify:

6. Does client have special problems being positioned in wheelchair? ☐ Yes ☐ No If yes, specify:

7. Supportive / protective devices? ☐ Yes ☐ No If yes, specify:

ADAPTIVE / POSITIONING/ASSISTIVE/PROTECTIVE EQUIPMENT

TOILETING

Continent of bowel and bladder: ☐ Yes ☐ No If no, specify:

If incontinent, how cared for (diapers, toileting schedule, etc.)?

COMMUNICATION

Verbal and comprehends: ☐ Yes ☐ No; if not, describe:

MEDICATION

MEDICATION, DOSE, ROUTE, FREQUENCY (INCLUDE VITAMINS, ETC.)	COMMENTS/REASON FOR TAKING

TREATMENTS

TYPES:

1 Dressing	7 Measurements	13 Tests	19 Ambulation skill	25 ADLs
2 Enema	8 Oxygen administration	14 Gastrostomy care	20 Transfer skills	26 Bladder program
3 Heat/cold	9 Special appliances	15 Tracheostomy care	21 Positioning	27 Bowel program
4 Infection control	10 Special skin care	16 Tube feeding	22 Progressive release	28 Community survival
5 Intake/output	11 Suctioning	17 Wound care	23 Self-feeding/swallowing	29 Other (specify)
6 Irrigation	12 Stoma care	18 Range of Motion Strengthening	24 Communication	

TREATMENT	FREQUENCY	BY WHOM

Does client cooperate with treatments as prescribed? ☐ Yes ☐ No If no, specify, what refused, frequency:

CLIENT OBSERVATION AT TIME OF VISIT

ATTENTION REQUIRED/FOLLOW-UP

☐ **URGENT – ACTION REQUIRED**

☐ Moderate Risk: Contact Social Worker/Case Manager for follow-up

☐ No changes to service plan recommended

NOTES

Source of information: (Client, guardian, caregiver, client file, nurse delegation records – state names and relationship as applicable).

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	TITLE	INITIALS	DATE