



## NURSING SERVICES ASSESSMENT

DATE OF VISIT	DATE OF LAST VISIT	DATE OF CARE
CASE MANAGER'S NAME		

### I. GENERAL INFORMATION

#### A. CLIENT INFORMATION AND HOUSING ARRANGEMENT

CLIENT'S NAME	DATE OF BIRTH	AGE	CLIENT ID	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
ADDRESS		CITY	STATE	ZIP CODE

RESIDENCE TYPE

<input type="checkbox"/> Parent Home	<input type="checkbox"/> Own Home (own, lease, rent from non-provider)
<input type="checkbox"/> Relative Home	<input type="checkbox"/> Adult Family Home
<input type="checkbox"/> Provider's Home	<input type="checkbox"/> Adult Residential Center

Current and correct on CARE  
 New Information:

#### B. SIGNIFICANT OTHER INFORMATION

NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)
ADDRESS	CITY                      STATE                      ZIP CODE

RELATIONSHIP TO CLIENT

<input type="checkbox"/> Legal Representative:	<input type="checkbox"/> Full Legal Guardian	<input type="checkbox"/> Partial Legal Guardian	<input type="checkbox"/> Power of Attorney
<input type="checkbox"/> Parent: <input type="checkbox"/> No Guardianship	<input type="checkbox"/> Full Legal Guardian	<input type="checkbox"/> Partial Legal Guardian	<input type="checkbox"/> Power of Attorney
<input type="checkbox"/> Other Relative/No Legal Relationship			
<input type="checkbox"/> Other/No Legal Relationship			

Current and correct on CARE  
 New Information:

#### C. ASSESSMENT PARTICIPANTS

##### ASSESSMENT PARTICIPANTS

NAME	TELEPHONE NUMBER (Include area code)

#### D. EMERGENCY CONTACT INFORMATION

Current and correct on CARE  
 New Information:

#### E. DEMOGRAPHIC AND LANGUAGE INFORMATION

Current and correct on CARE  
 New Information:

**II. HEALTH STATUS**

**A. HEALTHCARE PROFESSIONALS**

TREATING PROVIDER'S NAME	DATE LAST SEEN
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REASON

FINDINGS

TREATMENT/PRESCRIPTIONS

OTHER TREATING PROVIDER'S NAME	DATE LAST SEEN
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REASON

FINDINGS

TREATMENT/PRESCRIPTIONS

**B. DIAGNOSES**

LIST

Current and correct on CARE  
 New Information:

Concerns:

**C. MEDICATIONS AND ASISTANCE REQUIRED**

Current and correct on CARE  
 New Information:

Provider is working within their scope of practice  
 Nurse Delegation needed  
 Recommendations:

**D. BLADDER CONTROL, APPLIANCES, PROGRAM, AND MANAGEMENT**

Current and correct on CARE  
 New Information:

Concerns:

Recommendations:

E. BOWEL CONTROL, APPLIANCES, PROGRAM, AND MANAGEMENT

Current and correct on CARE

New Information:

Concerns:

Recommendations:

F. OTHER HEALTH INDICATORS

Speech, sight, hearing

Current and correct on CARE

New Information:

Recommendations:

Tobacco use, substance abuse

Current and correct on CARE

New Information:

Recommendations:

Allergies

Current and correct on CARE

New Information:

Recommendations:

Special diet

Current and correct on CARE

New Information:

Recommendations:

Nutrition, height, and weight

Current and correct on CARE

New Information:

Concerns:

Recommendations:

G. HEALTH INDICATORS RELATED TO THE HOUSEHOLD ENVIRONMENT

NOTE: Assessor is not expected to do a household inspection but is reporting on what is observed during visit. Suspicion of abuse of neglect requires a referral to APS (in-home), CRU (licensed facilities) or CPS.

Observations of conditions that place the client's health at risk:

**III. SKIN CARE ISSUES**

**A. SKIN PROBLEMS WITHIN THE LAST 14 DAYS (SKIN TEARS, RASH, BRUISES, WOUND CARE, PRESSURE ULCERS)**

Yes     No

**Risk indicators for skin breakdown related to pressure exist:**

- Incontinent of bladder or bowel
- Wheelchair dependent
- Quadriplegia
- Paraplegia
- Bedfast
- Diabetic
- Cognitive Impairment (CPS>3)
- Other:

**If any of the skin observation protocol risk indicators exist initiate the skin observation protocol.**

Skin observation protocol initiated:  Yes     No

If yes:

What was done?

What was found?

What action was taken?

What follow-up is needed?

Other skin care needs not related to the skin observation protocol:

Recommendations:

**B. TREATMENTS AND THERAPIES**

- Current and correct on CARE
- New Information:

Concerns:

Recommendations:

C. SELF-CARE TRAINING NEEDS

- Current and correct on CARE
- New Information:
  
- Concerns:
  
- Recommendations:

**IV. MOODS AND BEHAVIORS**

A. Impaired judgment, hallucinations, delusions, aphasia, verbally abusive, depression, withdrawn, assaultive, danger to self, other behavior impairments:

- Current and correct on CARE
- New Information:
  
- Concerns:
  
- Recommendations:

B. Accuses, rummages, takes belongings, sexual issues, exposes self, disrobes in public, combative during care, screaming:

- Current and correct on CARE
- New Information:
  
- Concerns:
  
- Recommendations:

C. Wandering

- Current and correct on CARE
- New Information:
  
- Concerns:
  
- Recommendations:

D. Short Term Memory

- Current and correct on CARE
- New Information:
  
- Concerns:

Recommendations:

**E. Long Term Memory and Orientation**

Current and correct on CARE

New Information:

Concerns:

Recommendations:

**F. Anxiety Issues**

Current and correct on CARE

New Information:

Concerns:

Recommendations:

**V. PERSONAL CARE NEEDS**

**A. Functional ADLS**

Current and correct on CARE

New Information:

Concerns:

Recommendations:

**B. Supervision Needs**

Current and correct on CARE

New Information:

Concerns:

Recommendations:

**VI. CAREGIVER INFORMATION**

**A. Caregiver Information**

Current and correct on CA

New Information:

Concerns:

Recommendations:

B. Provider Issues

Service provided by:  Individual provider  Homecare agency  AFH  BH

Number of IPs providing service:

**Training (applicable to IPs only):**

Training needs assessed. Provider name:

If serving an adult, the IP has completed the required training.

IP has not completed required training.

Training provided by RN to \_\_\_\_\_ (Name of Provider)  
Describe training:

Training recommendations for  
Describe recommendations:

**Performance:**

No concerns regarding caregiver performance

I have the following concerns regarding caregiver performance:

**VI. CAREGIVER INFORMATION**

**No concerns. No change required in client care plan.**

**Immediate actions taken by nurse:**

Describe issue and action taken:

Persons/agencies notified:

**Response required of case resource manager**

Recommended changes to the assessment and/or service plan based on new information entered into the following assessment section of this form:

- Client information or demographics
- Client living situation
- Significant other information
- Health Status (diagnosis, bowel and bladder control, med assistance, other)
- Health risks in environment
- Skin care issues
- Treatments and therapies
- Moods and behaviors
- Wandering
- Memory and orientation
- Anxiety issue
- Plan of care supervision and caregiver information
- Functional ADLS
- Supervision needs
- Provider issues

**Recommendations for additional nursing service activities:**

**Approximate date of next RN visit:**

**APS/CPS must be notified of suspicion of abuse, neglect, or exploitation. Call 1-866-363-4273 (1-866-ENDHARM).**

My signature indicates that I have assessed the above client. To the best of my knowledge, the information contained on this assessment is true and correct.

NURSE'S SIGNATURE	DATE
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<b>Distribution:</b>	Date sent:
<input type="checkbox"/> DDD	
<input type="checkbox"/> Family member/guardian (by request)	Date sent:

CRM RESPONSE TO RN RECOMMENDATIONS

<input type="checkbox"/> See addendum for additional documentation.	
CMR'S SIGNATURE	DATE