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| Transforming Lives | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)**Nursing Care ConsultantAssessment** | DATE OF REVIEW  | [ ]  ANNUAL [ ]  INITIAL[ ]  SIX (6) MONTH |
| DATE OF LAST REVIEW |
| PRISM SCORESCURRENT PRISM SCORE: PREVIOUS PRISM SCORE: ADMIT RISK SCORE: PREVIOUS ADMIT RISK SCORE: TPL / MCO:  |
| Client Demographic Information |
| CLIENT’S NAME | SEX**[ ]**  Male **[ ]**  Female | 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 |
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| CODE STATUS |
| DIAGNOSES |

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| ALLERGIES |

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| WEIGHT | HEIGHT | VACCINATIONSInfluenza? **[ ]**  Yes **[ ]**  No Pneumococcal? **[ ]**  Yes **[ ]**  NoComments below: |

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| Laboratory Work  |

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| 911 / ED Visits / Hospitalizations / Illnesses |

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| Upcoming Surgeries / Procedures |

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| Medications |

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| Updates / changes:  |

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| Communication |
| Verbal communication: |

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| Method(s) of communication: |

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| Ability to express wants / needs: |

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

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| Comments: |

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| Community Inclusion |
| School name and schedule: |

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| Activities / interests: |

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| Comments: |

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| Musculoskeletal |
| Musculoskeletal limitation:Mobility: |

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|  Equipment used: |

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|  Equipment needed: |

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| OT? **[ ]**  Yes **[ ]**  No PT? **[ ]**  Yes **[ ]**  No SLP? **[ ]**  Yes **[ ]**  No PROM? **[ ]**  Yes **[ ]**  No |

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| Comments: |

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| Respiratory |
| Vented: **[ ]**  Yes **[ ]**  NoVent schedule: |

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| Trach: **[ ]**  Yes **[ ]**  No. If Yes, reason: |

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|  Trach change frequency: |

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| Who does the trach change:  |

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| Trach care frequency: |

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|  Trach suctioning frequency: |

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| Oral suctioning frequency: |

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| Nasal suctioning frequency: |

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| Requires oxygen: **[ ]**  Yes **[ ]**  No |

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| Oximeter frequency: |

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| Passy Muir Valve (PMV) use / tolerance: |

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| Heated Moisture Exchange: **[ ]**  Yes **[ ]**  No |

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| Capping use / tolerance: |

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| Nebulizer: |

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| Cough assist: |

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| Respiratory vest / manual CPT: |

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| CPAP / BIPAP: |

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| Resuscitation within the last year: **[ ]**  Yes **[ ]**  No |

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| Comments: |

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| Genitourinary / Gastrointestinal |
| Diet: |

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| Oral feeder: **[ ]**  Yes **[ ]**  No |

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| JT: **[ ]**  Yes **[ ]**  No |

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| GT: **[ ]**  Yes **[ ]**  No |

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|  Who does the tube change: |

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|  Stoma care frequency: |

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| Tube feeding schedule and rate: |

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| Venting schedule: |

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| Farrell bag: |

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| Measurement of I & O: |

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| Continent of bowel: **[ ]**  Yes **[ ]**  No |

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| Bowel program: **[ ]**  Yes **[ ]**  No |

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| Continent of bladder: **[ ]**  Yes **[ ]**  No |

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| Use of catheter: **[ ]**  Yes **[ ]**  No |

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| Menstrual cycle: |

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| Comments: |

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| Neurology |
| History of seizures / type / frequency / intervention: |

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| Pain type / location / relieved by: |

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| Comments: |

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| Cardiac |

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| Endocrinology |

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| Vascular |
| Central lines: [ ]  Yes [ ]  NoComments: |

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| Integumentary |
| Skin integrity / pressure injuries:  |

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| History of pressure injuries: |

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| Skin Observation Protocol triggered: **[ ]**  Yes **[ ]**  NoDate:  |
| Who was SOP referred to: |

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| Wound care: |

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| Comments: |

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| Emergency Preparedness |
| Correct size of AMBU bag for resuscitation (what size): **[ ]**  Yes **[ ]**  NoNeonatal: **[ ]**  Yes **[ ]**  No Pediatric: **[ ]**  Yes **[ ]**  NoAdult: **[ ]**  Yes **[ ]**  No |

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| Emergency To Go Bag: **[ ]**  Yes **[ ]**  NoBack-up ventilator / concentrator: **[ ]**  Yes **[ ]**  No **[ ]**  N/ABack-up batteries: **[ ]**  Yes **[ ]**  No **[ ]**  N/AGenerator: **[ ]**  Yes **[ ]**  No |

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| Are you connected with local police / fire departments / Smart 911: **[ ]**  Yes **[ ]**  NoComments: |

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| Client Observation at Time of Visit |

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| Issues / Concerns |

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| NCC Recommendations |
| CLINICAL CRITERIA TOOL SCORE |

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| RECOMMENDATIONS |

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| 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 |