HOME HEALTH SOLUTIONS GROUP – NURSING ASSESSMENT FORM

Patient's Name ____ **Gender** __________ **MR#** ___________ **Date** _____________
Primary Diagnosis ____ **Secondary Diagnosis** ____
Other Pertinent Diagnosis ____ **PCP name** ____
Other Physician Name ____

Prognosis: ( ) Poor ( ) Guarded ( ) Fair ( ) Good ( ) Excellent
Vital Signs: Height:________ Weight:________ Temp:________ Pulse:_________ Resp:________ B/P:_________
Allergies:____ **Diet:** ____

Past history:____
____

Support System: Lives alone ( ) Yes ( ) No Family composition: _________________________ Legal Next to Kin: _________________ Tel: _____________
Caregiver's name: ____________________________________ Address: ( ) same as client ____

Caregivers ability to assist patient / able to provide: Personal care: ( ) Yes ( ) No Mobility: ( ) Yes ( ) No Med Admin. ( ) Yes ( ) No
Prepare/serve meals ( ) Yes ( ) No Maintain safe/clean environment ( ) Yes ( ) No Perform/ assist with procedures ( ) Yes ( ) No
Caregiver name: _____________________________________ Days / Time available: __________ Comments: _____________________________________

Advanced Directives: Pt. has a living will ( ) Yes ( ) No
Special Provisions included: ( ) No resuscitation ( ) No mech. Vent. ( ) Med. Support only ( ) No feeding tubes ( ) Other

ADL's: Need assistance in the following areas: ( ) Bathing/Showering ( ) Toileting ( ) Ambulation ( ) Dressing ( ) Transfers ( ) Eating/Meal preparation
( ) Medication reminders ( ) Shopping ( ) Housekeeping ( ) Laundry ( ) Other: ____

Safety Hazards in the home: ( ) Sound structure ( ) Safe placement of cords, rugs and furniture ( ) Adq. heating and ventilation ( ) Adq. Cooking facility
( ) Adequate Plumbing/sanitation/ running water ( ) Adequate sleeping arrangement ( ) Safe gas/electric appliances ( ) grounded plug for equipment
( ) Enough electrical outlets for equipment ( ) Working telephone in the home ( ) Safe storage for supplies/equipment/meds? ( ) Exits free of obstruction
( ) Working smoke detectors? ( ) Fire extinguisher in home? ( ) Infestations of pests? ( ) Neighborhood safe? Comments: ___________________________

Neurological / Mental Status: ( ) Pt. denies problems ( ) Alert/Oriented X3 ( ) Headache ( ) Fine/gross hands tremor ( ) PERRLA L/R ( ) Dominant side R/L
( ) Aphasia ( ) Hemiplegia ( ) Paraplegia/Quadriplegia ( ) Numbness ( ) Seizures ( ) Unsteady Gait/Ataxia ( ) Syncope ( ) Vertigo ( ) P Balance ( ) Dizziness
( ) Weakness ( ) Oriented ( ) Disoriented ( ) Comatose ( ) Forgetful ( ) Agitated ( ) Confused ( ) Anxious ( ) Depressed ( ) Other: ________________

Risk Factors: ( ) Smoking ( ) Obesity ( ) Alcohol dependency ( ) Drug abuse ( ) None of the above ( ) Other: ______________________________

Functional limitations: ( ) Amputation __________ ( ) Bowel/Bladder incontinence ( ) Contracture ( ) Hearing ( ) Paralysis ( ) Endurance ( ) Ambulation
( ) Speech ( ) Vision ( ) Poor manual dexterity ( ) Legally blind ( ) Dyspnea ( ) Poor hand-eye coordination ( ) Unsteady Gait ( ) Poor balance ( ) Other

Activities permitted: ( ) Complete Bedrest ( ) Bedrest/BRP ( )Up as tolerated ( ) Transfer bed to chair ( ) Independent in home ( ) Other:_____________
_

Fall Precaution: Pt. has risk of Fall? ( ) Yes ( ) No Fall Precaution Education Provided? Yes ( ) No ( )

Assistive device: ( ) Cane ( ) Quad cane ( ) Walker ( ) Rolling walker ( ) Crutches ( ) Reg. wheelchair ( ) Electric wheelchair ( ) Other: ____________

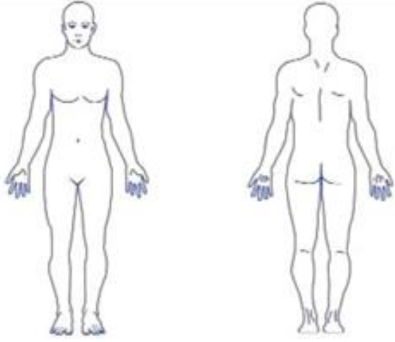
Equipment: ( ) Hospital bed ( ) Commode ( ) Hoyer lift ( ) Nebulizer ( ) Bath chair ( ) Apnea machine ( )oxygen concentrator ( ) Other: ______________
Device/equipment needed at home: ____

Cardiovascular: ( ) Pt. denies problems ( ) Chest pain ( ) Palpitations ( ) Vertigo ( ) Syncope ( ) Pulse deficit ( ) PVD ( ) Cyanosis ( ) Claudication
( ) Varicose veins ( ) Murmur ( ) Fatigue ( ) Edema ( ) Cardiac pacemaker date__/__/__ last date checked__/__/__ type:________ ( ) Other: _________

Respiratory: ( ) Client denies problems Lung: ( ) clear ( ) left ( ) right (wheezes/rhonchi, crackles/rales, diminish /absent)
Capillary refill less than 3 sec/ great than 3 sec, ( )orthopnea ( ) hemoptysis ( ) SOB at rest/minimal exertion/moderate exertion/when walking > 20 feet
( ) Cough productive/non-productive describe:____________________________ Oxygen @ __ LPM via nasal cannula/mask/trach. Trach size/type:_______
Other:____

Gastrointestinal/abdomen: ( ) Pt. denies problems ( ) Heartburn ( ) Distention ( ) Flatulence ( ) Nausea ( ) Vomiting ( ) Constipation ( ) Ascites
( ) Cramping ( ) Bleeding ( ) Anorexia ( ) Dysphagia ( ) Diarrhea ( ) Bowel incontinence Bowel sounds:_______________ Last BM:________________
Ostomy: ____________________ Stoma:_____________________________________ Other:____

Patient's Name ____ **MR# m**__________ **Date** ___________



Integument Assessment: Skin: ( ) Client denies problems
Color: ( ) Normal ( ) Pink ( ) Pale ( ) Cyanotic ( ) Jaundiced
Turgor: ( ) Poor ( ) Fair ( ) Good
Temperature: ( ) Hot ( ) Warm ( ) Cool Condition: ( ) Dry ( ) Moist ( ) Ecchymosis
( ) Rasch ( ) Petechie ( ) Iitch ( ) Redness ( ) Bruises ( ) Scaling
Comment:____
Open wound/decubitus/incision/diabetic ulcer location:____________________
Describe: _____________________________
Skin Problems: ( ) Lesion ( ) Scaling ( ) Lesion ( ) Wound ( ) Ulcer ( ) Incision ( ) Petichie
( ) Rasch ( ) Ostomy ( ) Cyst ( ) Masses ( ) Itch ( ) Other
Describe: ____

GU/GYN: ( ) Pt. denies problems ( ) Frequency ( ) Urgency ( ) Incontinence ( ) Nocturia ( ) Polyuria ( ) Dysuria ( ) Oliguria ( ) Pain ( ) Burning ( ) Odor
( ) Lithiasis ( ) Hematuria ( ) Infections Ostomy:____________ Catheter: ( ) Condon cath ( ) Foley cath ( ) Suprapubic cath size:___F with ____cc
( ) Mastectomy R/L ( ) Hysterectomy ( )Vaginal bleeding ( ) Discharge ( ) BPH/TURP ( ) Other:______________________________

Musculoskeletal: ( ) Pt.denies problems ( ) Fracture:__________ ( ) Contracture joints:________ ( ) Atrophy:_________ ( ) Decreased ROM: __________
Pain: location:________________ Intensity: 1 2 3 4 5 6 7 8 9 10 Duration: ( ) Less often than daily ( ) Daily, but not constantly ( ) All of the time

Pain Assessment: Area: _____________ What makes pain better? _____________ What makes Pain Worse? _____________
Medication taken for Pain and frequency: ____

Eye: ( ) Pt. denies problems ( ) Impaired vision ( ) Cataracts R/L ( ) Retinopathy ( ) Blind R/L ( ) Legally blind ( ) Glasses ( ) Contacts R/L ( ) Blurred vision
( ) Prothesis R/L ( ) Glaucoma ( ) Other: ____________

Nose: ( ) Pt.denies problems ( ) Congestion ( ) Epistaxis ( ) Loss of smell ( ) Sinus problem ( ) Other:__________________________

Throat: ( ) Pt.denies problems ( ) Dysphagia ( ) Hoarseness ( ) Lesions ( ) Ssore throat ( ) Other: ___________________________

Mouth: ( ) Pt. denies problems ( ) Dentures upper/lower/partial/total ( ) Gingivitis ( ) Toothache ( ) Ulcerations ( ) Other: ______________

Communication Assessment: Primary Language ________ Speech/Language Barrier ( ) Caregiver ( ) Patient Interpreter needed ( ) Yes ( ) No
Hearing Loss ( ) Yes ( ) No Aide used ( ) Yes ( ) Ear discharge or pain ( ) Yes ( ) No Visual impairment ( ) Blind ( ) Glasses ( ) Contacts Redness/Itching/Burning
Reading/writing problems ( ) Patient ( ) Caregiver Slow learner ( ) Patient ( ) Caregiver Comments: ___________________________

Activities of Daily	Unable to Do	Minimal Assistance	Moderate Assistance	Maximal Assistance	Independent
Ambulation					
Stairs					
Dressing					
Feeding					
Household Tasks					
Transfer					
Self Care (Groom./Bath)					
Toileting					

Reviewed and Discussed with Patient/Caregiver: ( ) Services provided ( ) Freq. and Duration of Service ( ) Goals of Service ( ) Complaint Right and Proced.
( ) Pt. Rights/Responsibilities/State Hotline No. ( ) Home Safety/Emergency. Info ( ) Reporting Abuse/Neglect/Exploitation ( ) Agency Drug Free Work Policy
( ) Confidentiality/Release of Records Pol. ( ) Pt./Caregiver participated in the development of Care Plan ( ) Other: ____________________

R.N. Name: __Ivan R Valdes Abreu, RN ______________ **R.N. Signature:** ______________________ **Date:** __________

Comments & Observations (use additional sheets)