 **TRINITY CARE XYZ**

**INITIAL ASSESSMENT**

DATE OF ASSESSMENT: TIME: \_\_\_\_\_\_\_\_\_AM/PM

**EMERGENCY PRIORITY CODE:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT NAME: MARTE RUBEN** DOB: Age

**ADVANCED DIRECTIVE? YES NO LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES:** NKA OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENDER: MALE LANGUAGE SPOKEN: ENGLISH

**CLIENT LIVES:** ALONE WITH SPOUSE WITH FAMILY OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT** 201-466-8797 RELATIONSHIP: MOTHER

PHONE #: \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ 2ND PHONE #: \_\_­­­­­­\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

**NUTRITIONAL STATUS:** REGUALR DIET LOW SALT DIABETIC

OTHER/DESCRIBE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

MEDICAL DIAGNOSIS:  Cerebral Palsy
Skilled Needs: Gtube feedings, assists with ADLS

**PAST MEDICAL HISTORY:** *(Please circle all that apply)* **CARDIAC PULMONARY ENDOCRINE NEUROVASCULAR DEMENTIA/ALZHEIMERS MUSCULAR/SKELETAL GASTRO/INTESTINAL INTEGUMENTARY /SKIN REPRODUCTIVE PSYCH/SOCIAL OTHER**

*PLEASE DESCRIBE ALL MEDICAL HISTORY CIRCLED ABOVE:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VITAL SIGNS:**

TEMP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PULSE: \_\_\_\_\_\_\_\_\_\_\_\_ RESPIR: \_\_\_\_\_\_\_\_\_\_\_ B/P \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Pain:**  Yes No

**PAIN SCALE USED**: NUMERIC \_\_\_\_\_\_\_\_\_\_ FLACC\_\_\_\_\_\_\_\_\_ FACES (PEDS) \_\_\_\_\_\_\_\_\_

Rated as: \_\_\_\_\_\_\_\_\_\_\_ out of \_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Character: Ache Sharp Dull Pressure Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Precipitating Factors: Ambulation Transfer Weight bearing Activity

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If NO pain noted, last time pain was present (if at all) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current pain medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is pain med effective? Yes No Intensity after pain medication: \_\_\_\_\_

Other relief measures : Rest Music Reading Prayer Deep Breathing

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FUNCTIONAL STATUS:**

**MOBILITY:** \_\_\_\_\_\_\_ AMBULATES INDEPENDENTLY \_\_\_\_\_\_ WALKS WITH CANE/WALKER

\_\_\_\_\_ NEEDS W/CHAIR \_\_\_\_\_\_ BEDREST WITH BRP \_\_\_\_\_\_\_\_ BED REST ONLY

**AUDITORY:**  \_\_\_\_ NO PROBLEMS \_\_\_\_\_HOH WEARS HEARING AIDS: \_\_\_\_\_\_RT \_\_\_\_\_\_\_LEFT

**VISION:** \_\_\_\_\_\_ WEARS GLASSES \_\_\_\_\_\_ LEGALLY BLIND \_\_\_\_\_\_ NO VISION

**SPEECH:** \_\_\_\_\_ NO DEFICITS \_\_\_\_\_\_ DIFFICULTY SPEAKING \_\_\_\_\_ DOES NOT SPEAK

**NEEDS ASSISTANCE WITH:** DRESSING BATHING/SHAMPOO ORAL CARE GROOMING

 FEEDING BOWEL/BLADDER MEDICATION TRANSFERRING FROM BED TO CHAIR

**\*\*REVIEW OF SYSTEMS\*\***

**HEAD:** □ NO PROBLEMS □ HEADACHES □ MIGRAINES □ DIZZINESS □ BUMP(S)

□ BRUISING □ LACERATION □ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EYES:** □ NO PROBLEMS □ RED □ DRY □ IRRITATED □ DISCHARGE □ CATARACTS □ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOSE:** □ NO PROBLEMS □ BLEEDING □ DRAINGAGE □ NASAL FLARE

 □ SINUS INFECTION □ MOUTH BREATHER

**MOUTH/THROAT:**  □ NO PROBLEMS □ DECREASE IN TASTE □ DRY MOUTH

DENTURES Upper Lower Both □ SORE THROAT □ HOARSENESS □ DYSPHAGIA

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARDIAC:** □ NO PROBLEMS □ NSR □ MURMURS NOTED □ PACEMAKER JVD

 □ PALPATATIONS □ ABNORMAL RHYTHM □ HYPERTENSION □ HYPOTENSIVE

 **□ C/O CHEST PAIN** If Yes: Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_Type \_\_\_\_\_\_\_\_\_\_\_Location\_\_\_\_\_\_\_\_\_\_

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PULMONARY:**   **No Problem**  SOB DOE Wheeze

Cough: Productive Non- Productive Secretions Yes No Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oxygen: Yes No Continuous Intermittent ***IF YES*** LPM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ventilator Dependent ***IF YES*** Type of ventilator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trach: Yes No ***IF YES*** Size\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoker Yes No

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BREAST:** □ NO PROBLEMS □ PAIN/TENDERNESS □ BRUISING □ DIMPLING

 □ LUMP(S) □ MASTECTOMY OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CIRCULATORY:**  **□ NO PROBLEMS**  □ VARICOSE VEINS □ PHLEBITIS/HISTORY of

 □ VENIOUS STASIS ULCER If yes location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ COLD EXTREMITIES □ POOR CAPILLARY REFILL □ NAIL CLUBBING □ CYANOSIS

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GASTRO/INTESTINAL**:  **□ NO PROBLEMS** □ DIARRHEA □ CONSTIPATION □ NAUSEA

 □ VOMITTING □ EXCESSIVE FLATULENCE □ PAIN/TENDERNESS □ HERNIA

 □ STOMACHACHES □ BLOOD IN STOOL □ RECENT CHANGE IN BOWEL HABITS

 OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NUTRITION:** □ REGULAR DIET □ SOFT FOODS □ LOW SODIUM □ DIABETIC DIET OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ POOR APPETITE □ GOOD APPETITE □ G-TUBE

FORMULA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RATE: \_\_\_\_\_\_\_\_\_\_\_\_ VOl: \_\_\_\_\_\_\_\_\_\_\_\_\_ FREQ: \_\_\_\_\_\_\_\_

 INTERMITTANT FEEDINGS CONTNUOUS FEEDINGS PUMP USED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENITOURINARY:** □ NO PROBLEMS

□ URGENCY□ NOCTURIA BURNING □ FREQUENCY HEMATURIA OLIGURIA DYSURIA

RETENTION □ PAIN □ INCONTINENT □ ILIOCONDUIT

□ FOLEY CATHETER: CATHETER SIZE: \_\_\_\_\_\_\_\_\_\_\_

**REPRODUCTIVE: □ FEMALE:** □ NO PROBLEMS □ VAGINAL BLEEDING □ MENOPAUSAL □ HYSTERECTOMY OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ MALE:** □ NO PROBLEMS □ PAIN/TENDERNESS □ PROSTATE ENLARGEMENT

 □ SWELLING □ TESTICULAR ENLARGEMENT □ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ENDOCRINE:** □ NO PROBLEMS

□ DIABETIC □ HYPOGLYCEMIA □ HYPERTHYROIDISM

□ HYPOTHYROIDISM OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MUSCULAR/SKELETAL:** □ NO PROBLEMS

□ WEAKNESS □ PAIN STIFFNESS CONTRACTURES □ SHAKING

 □ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INTEGUMENTARY:** □ NO PROBLEMS □ RASH\* □ BRUISING\* □ SKIN TEAR(S)\*

□ DECUBITUS ULCER(S)\* □ PRUITIS \* INCISION\* □ ECZEMA

\*DESCRIBE SIZE/STAGE/LOCATION/OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**NEUROLOGICAL:** □ NO PROBLEMS

ORIENTATED TO: □ PERSON □ PLACE □ TIME □ PUPILS EQUAL/REACTIVE HAND GRASPS WNL

□ SEIZURES □ CONFUSED □MEMORY LOSS: SHORT TERM LONG TERM ABLE TO FOLLOW DIRECTIONS NUMBNESS TINGLING VERTIGO

 TREMORS □ SLURRED SPEECH □ SLEEPINESS □ STUPOROUS □ AGITATED □ LETHARGIC □ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**PSYCH/SOCIAL:**  □ NO PROBLEMS

□ COOPERATIVE □ ANXIOUS □ DEPRESSED □ AGGRESSIVE MEMORY DEFECT IMPAIRED DECISION

MAKING □ HOSTIL □ HISTORY OF ALCOHOL ABUSE □ HISTORY OF DRUG ABUSE □ UNCOOPERATIVE

**CLIENT UNDERSTAND THE PLAN OF CARE** YES NO COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP PATTERNS:** □ NO PROBLEMS □ INSOMNIA □ DISRUPTED SLEEP

**\*\*HOME SAFETY REVIEW/FALL ASSESSMENT””**

Is smoking allowed in the home? Yes No

Are there working smoke detectors/alarms in the home? Yes No

Is there an accessible escape in case of fire? Yes No

Are there overcrowded electrical outlets? Yes No

Is a portable heater used in the home? Yes No

Is the stove/oven Electric Gas

Are there any flammable items near the range top? Yes No

Are there any loose rugs, linoleum tiles or mats that could cause tripping? Yes No

Are there loose wires/cords/materials around living areas that could cause trips? Yes No

Are living areas free of clutter? Yes No

Is furniture steady and secured? Yes No

Is the walker/cane/assistive device within arms-reach of client? Yes No

Does the client experience episodes of dizziness/vertigo or unsteadiness? Yes No

Are there proper assistive devices for the client that would help prevent a fall? Yes No

Are there animals in the home? Yes No

If so, are they adequately cared for? Yes No By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are the animals well behaved and non-threatening? Yes No

Is the client taking anti-hypertensive medication? Yes No

Is the client taking antipsychotic medication? Yes No

Does the client take a sleep aid at night? Yes No

**Equipment in Home**:

 Wheelchair Walker Cane Hospital Bed Hoyer Lift Commode Shower Chair Oxygen Concentrator Oxygen Tank Nembulizer CPAP Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Number of supplier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:**

NAME PURPOSE DOSE/FREQUENCY

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nursing Diagnosis:*

1. *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ related to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*
2. *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ related to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*
3. *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ related to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*

**IHSN:** Education Initiated re: Care Treatments Medications

**Plan of Care Initiated** Yes No

**Discharge Planning Initiated** Yes No

**At Reassessment for IHSN:** Review of Medication Profile, Medication Administration Record (if applicable), Nursing Progress Notes, Nursing Plan of Care, Physician Orders reviewed with Field Nurse? Yes No

Review of Office Record completed by the Nursing Supervisor? Yes N**o**

**At PCS Reassessment:**

Name and title of Staff Member Present:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Staff Member Supervised Yes No

*Services already in place:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Additional Services Needed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Collateral Contacts: (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***The Primary Care Physician has provided a Certificate of Need for PCS Services. Yes No***

***The Emergency Plan has been reviewed with the client/family member. Yes No***

Nursing Supervisor Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nursing Supervisor Signature/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_