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

NAME OF LPN INN HOME AT TIME OF VISIT :

**CLIENT: MARTE RUBEN**

DOB:

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

**NEW OR CHANGE IN MEDICAL CONDITION:** *(Please circle all that apply)* **NO CHANGE** **CARDIAC PULMONARY ENDOCRINE NEUROVASCULAR DEMENTIA/ALZHEIMERS MUSCULAR/SKELETAL GASTRO/INTESTINAL INTEGUMENTARY /SKIN REPRODUCTIVE PSYCH/SOCIAL OTHER**

*PLEASE DESCRIBE ALL NEW CHANGES IN MEDICAL STATUS CIRCLED ABOVE:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS CASE MONITORING VISIT WITHIN 60 DAYS OF LAST VISIT? YES NO**

**IS THIS VISIT DUE TO A RECENT HOSPITALIZATION DISCHARGE OR INTERRUPTION OF SERVICE? YES NO**

**IF YES, EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY PRIORITY CODE/EMERGENCY PLAN REVIEWED? YES NO**

**IS THERE A CHANGE IN PRIORITY CODE/EMERGENCY PLAN? YES NO**

**IF YES, WHAT IS THAT CHANGE?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS THERE A CHANGE IN THE EMERGENCY CONTACT: YES NO IF YES, WHO IS THE NEW EMERGENCY CONTACT?** Adriana Marte

**RELATIONSHIP: MOTHER PHONE #: \_**201-466-8797

IS THERE A CHANGE IN THE ADVANCED DIRECTIVE? YES NO IN LOCATION? YES NO

IF YES, WHAT ARE THOSE CHANGES? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE THERE ANY NEW PROBLEMS/CONDITIONS TO THE PATIENT SINCE LAST VISIT? YES NO**

**IF YES, WHAT ARE THEY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** NKA YES NO **ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FUNCTIONAL STATUS: IS THERE A CHANGE** IN FUNCTIONAL STATUS FROM THE PREVIOUS ASSESSMENT OF THIS CLIENT? YES NO

IF YES, EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

**DOES THE RN ASSESSMENT DETERMINE THE NEED FOR VITAL SIGNS? YES NO**

**VITAL SIGNS:**

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

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

DESCRIPTION/LOCATION OF PAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DURATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PSYCH/SOCIAL:**  □ NO PROBLEMS □ NO CHANGE □ COOPERATIVE □ ANXIOUS □ DEPRESSED □ AGGRESSIVE MEMORY DEFECT IMPAIRED DECISION MAKING □ HOSTILE □ HISTORY OF ALCOHOL ABUSE □ HISTORY OF DRUG ABUSE □ UNCOOPERATIVE

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

**NUTRITION:** □ NO CHANGE □ REGULAR DIET □ SOFT FOODS □ LOW SODIUM □ DIEBETIC DIET □ POOR APPETITE □ GOOD APPETITE □ G-TUBE:

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

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

**IS THIS A CHANGE FROM THE PREVIOUS ASSESSMENT?**  YES NO

*New Support Services in place: No Yes If yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

C**LIENT LIVES:** ALONE WITH SPOUSE WITH FAMILY

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

**PLAN OF CARE REVIEW:**

**Does the Plan of Care continue to meet the client’s needs? Yes No**

**Does the Plan of Care need revision? Yes No if yes, what are those revisions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

The Plan of Care has been reviewed with the LPN. Yes No

**CLIENT/FAMILY MEMBER UNDERSTANDS THE PLAN OF CARE** YES NO COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*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

**IS THIS CLIENT AT RISK OF FALLING BASED ON THE ABOVE ASSESSMENT? Yes No**

**IS FAMILY AWARE OF CLIENT’S FALL RISK? Yes No**

WHAT WILL BE DONE TO PREVENT A FALL FOR THIS CLIENT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*New Nursing Diagnosis, if applicable:*

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

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

*Original Signature of Physician obtained if needed? Yes No*

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

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

LPN Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LPN Signature/title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_