

NURSE'S ASSESSMENT VISIT REPORT

Field Office:		Case Manager:	
1A. Client's Name: [REDACTED]		Birthdate: [REDACTED]	
Address: [REDACTED] New York NY [REDACTED]		Apt # [REDACTED] Floor: [REDACTED]	
Social Security: [REDACTED] Medicaid # [REDACTED]		Medicare <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Medicare # _____	
ASSESSMENT AGENCY: <input type="checkbox"/> Home Attendant <input type="checkbox"/> Housekeeper <input checked="" type="checkbox"/> Home Health Agency <input type="checkbox"/> Other _____		Billable Hours Per Week: 4h/7 days Authorized Hours Per Week: 28 hours	
		Recommendation for Authorization of Services (in hours) 7 days, 4 hours <input type="checkbox"/> Start <input type="checkbox"/> Continue <input type="checkbox"/> Increase Tasks <input type="checkbox"/> Deny <input type="checkbox"/> Decrease Tasks <input type="checkbox"/> Discontinue	
PRESENT AT INTERVIEW: <input type="checkbox"/> HA <input type="checkbox"/> HK <input checked="" type="checkbox"/> HHA <input type="checkbox"/> Relative/Friend Source of Information: Patient		RECOMMENDED LEVEL OF CARE <input checked="" type="checkbox"/> Home Attendant <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Housekeeper <input type="checkbox"/> Other _____	
Contact Person: [REDACTED] (daughter)		Telephone #: 347- [REDACTED]	
B. DIAGNOSIS: Primary: Systemic Lupus Erythematosus Secondary: COPD		ICD-9 CODE If Available	
CLIENT PRIMARY MEDICAL PROVIDER: Name: [REDACTED] Telephone # 212- [REDACTED]		Regularly Scheduled Appointments-Day/Time-Frequency	
IIA. IMPAIRMENTS:		YES	NO
Speech <input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Dom. Hand/Arm <input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other Hand/Arm <input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Lower Extremities <input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cardiac Function <input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Respiratory Function <input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Obesity <input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMENTS: Pt. has unsteady gait, ordered cane and physical therapy eval. Pt has COPD, and tobacco drug use, diminished endurance becomes short of breath, pt reports holds on to walls & furniture for balance.			
ADDITIONAL FUNCTIONAL IMPAIRMENTS			
B. BLADDER CONTROL <input type="checkbox"/> Continent <input checked="" type="checkbox"/> Sometimes Incontinent <input type="checkbox"/> Totally Incontinent <input type="checkbox"/> Catheter Indicate Type <input type="checkbox"/> Indwelling <input type="checkbox"/> Texas Frequency: _____ Urgency: _____		BOWEL CONTROL <input checked="" type="checkbox"/> Continent <input type="checkbox"/> Sometimes Incontinent <input type="checkbox"/> Totally Incontinent <input type="checkbox"/> Ostomy Frequency: _____ Urgency: _____	
C. SIGHT: <input type="checkbox"/> Total Blindness <input type="checkbox"/> Legally Blind <input checked="" type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses		HEARING: <input type="checkbox"/> Total Deafness <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Lip Reading <input type="checkbox"/> Can Interpret Loudness	

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III. A. MOBILITY	Can Indep.	Can W/ Mech Aid	Can W/Aid of Person	Can-not	B. CLIENT ENDURANCE <i>Pt holds on to walls for balance do incontinence. Ordered cane, commode/shower chair/bathroom b</i>
Walk or Wheel Inside	/		/		<input type="checkbox"/> Tolerates Distances(250Ft +)
Walk or Wheel Outside			/		<input checked="" type="checkbox"/> Needs Intermittent Rest
Get Up From Seated Position	/		/		<input type="checkbox"/> Barely Tolerates Short Activities
Get Up From Bed	/		/		<input type="checkbox"/> No Tolerance
Transfer To Commode					TELEPHONE USAGE Is Client Able to Use Telephone?
Transfer To Wheelchair					<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, Explain
Use Bedpan					Does Client have a Personal Emergency Response System <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
C. CLIENT PREFERENCES FOR SERVICE HOURS AND ACTIVITIES: Use 24:00 Hour Clock			D. CLIENT STATUS VARIATIONS DURING DAY Include Any Peak Periods Of Functioning(e.g. Early Or Later In Day)		
Rise Time	8:00		<i>Generalized weakness & pt do of poor sleeping pattern, unrestful sleep.</i>		
Breakfast	9:00				
Bathing	10:00				
Lunch	12:00				
Dinner	17:30				
Bedtime	22:00				
IV. A. MENTAL STATUS	YES	NO	COMMENTS		
Oriented To Time, Person, Place	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>50 year old female, lives alone, hospitalized on 9/10/08 & 9/17/08 for chest pain, triple pneumonia, collapsed lung, newly diagnosed Systemic Lupus Erythematosus. Observed pt crying about difficulty managing medical health problems, daughter who is diagnosed cancer, leads stressful career as community activist. Pt. denies suicidal thoughts & sees psychiatrist (1x) month, and is on new multiple medication regimen.</i>		
Alert	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
Able To Learn	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
Able To Direct Worker	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
Able To Manage Affairs	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Impaired Recent Memory	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
Agitated	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
Wanders If Unsupervised	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
Depressed	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
Anxious	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
B. JUDGEMENT:			Appropriate	Fair	Inappropriate
What If Your Home Attendant Could Not Get Here			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What Would You Do If There Was A Fire While You Were Alone?			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What Would You Do If You Were Alone And You Got Chest Pain That Would Not Go Away?			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Someone Rings Your Bell, What Do You Do?			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Any Evidence Of The Following, Please Describe. Include Source Of Information And Indicate Action Taken And Recommended Follow-up:					
<input type="checkbox"/> Verbally Abusive					
<input type="checkbox"/> Physically Assaultive					
<input type="checkbox"/> Suicidal Ideation					
<input type="checkbox"/> Self-Endangering Behavior					
<input type="checkbox"/> Known Psychiatric Disorder					

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V. FUNCTIONAL AIDS *equipment on order* *Cane shower chair commode bath bars*
 What Functional Aids Does Client Have:

Are Functional Aids Being Used Correctly? Yes No If No, Specify:

What Functional Aids Does Client Need And Not Have? *Cane/ Shower chair/ commode/ Bath bars* Have They Been Ordered? Yes No

Name of Supplier:

	A. SKILLED NEEDS: Does Client Need Any Of The following? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Specify Frequency and Provider		B. ADDITIONAL SERVICES/REFERRAL: Indicate Whether The Client Should Be Referred For, Or Is Receiving The Following:				
	Frequency	Provider		Referral Needed <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving Services <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Decubitus Care			Psychiatric Evaluation			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Sterile Dressings			Rehabilitation Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
ROM/Therapeutic Exercises			Other:				
Enema							
Ostomy Care			C. CURRENT MEDICATIONS				
Oxygen Administration			Medication	Dosage	Frequency	Route	Can Client Self Administer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Therapy			Predisone	20mg	DAILY	PO	
Catheter Irrigation/Insertion			Diltiazem	300mg	DAILY	PO	
Tube Irrigation			Plaquenil	200mg	2x Daily	PO	
Tube Feeding			Lisinopril	10mg	Daily	PO	
			Naproxen	375mg	2x Daily	PO	
			Zocor	20mg	Daily	PO	
Suctioning			Senna	86mg/2tab	Daily	PO	
			Calcium	1 tab	2-3x daily	PO	
Monitor Vital Signs	2 x wk	/	Tylenol	325mg 2 tabs	PRN every 6 hours	PO	
Other:			Albuterol	2 puffs (90mcg)	PRN every 4 hours	inhaler	
			Atravent	2 puffs	every 6 hours	inhaler	

Does Medication Need To Be Prepared For Client? Yes No
 If Yes, Who Will Prepare? _____

COMMENTS: Client is *70* year old female, lives alone. h/o of systemic lupus erythematosus, COPD, HTN, depression, Tobacco Drug Use, obesity. Pt moves slowly with unsteady gait holds onto walls & furniture for balance and diminished endurance. Client requires assistance with ADL's, IADL's, shopping, laundry, housekeeping, escort to MD appts. Pt denies suicidal thoughts and sees psychiatrist (1x) month.

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VII. RECOMMENDED PLAN OF CARE: Indicate The Personal Care Services Required By The Client, Using The Following Codes To Identify The Providers.

- Key:**
- | | | | |
|--------------------|---------------------|--------------------|------------|
| 1. Family Member | 4. Home Attendant | 7. Other - Specify | |
| 2. Friend/Neighbor | 5. Home Health Aide | M = Minutes | qd = Daily |
| 3. HouseKeeper | 6. Nurse | P.E. = Per Event | |

TASK	Not Needed	Indep.	Client Assistance		Frequency		Total Weekly Time	Prov.	Time of Day
			Some	Total	Daily	Weekly			
7. Prepare for Bed	✓		<input type="checkbox"/> 20m/qd	<input type="checkbox"/> 30m/qd					
8. Medical Supplies/ Equipment Help in Using (e.g. Walker)			<input checked="" type="checkbox"/> 20m		✓	7	140	4	AM/PM
9. Dressing: (per event)									
<input type="checkbox"/> Change Nonsterile Dressing			<input type="checkbox"/> 10m/pe	<input type="checkbox"/> 10m/pe					
<input type="checkbox"/> Reinforce Dressing			<input type="checkbox"/> 10m/pe	<input type="checkbox"/> 10m/pe					
10. Stable Colostomy Care (per event)			<input type="checkbox"/> 15m/pe	<input type="checkbox"/> 15m/pe					
11. Foley Catheter Care (Empty Bag/Wash Area)				<input type="checkbox"/> 10m/pe					
12. Texas Catheter Care				<input type="checkbox"/> 10m/pe					
13. Bedbound Positioning/Turning				<input type="checkbox"/> 10m/pe					
14. Escort - <input checked="" type="checkbox"/> Stay with Client			(240 minutes MD appts)			every week	60	4	AM/PM
15. Prepare For Day Care Or Special Treatment (e.g. Dialysis)									
16. Other									
Nutritional Activities									
17. Meal Preparation			<input checked="" type="checkbox"/> 30m/qd	<input type="checkbox"/> 60m/qd	/	7	210	4	AM PM
<input checked="" type="checkbox"/> Breakfast					/	7	↓	4	AM PM
<input checked="" type="checkbox"/> Lunch					/	7	↓	4	AM PM
<input checked="" type="checkbox"/> Dinner					/	7	↓	4	AM PM
<input checked="" type="checkbox"/> Snack(s)				<input type="checkbox"/> 5m/pe	/	7	↓	4	AM PM
18. Special Diet			<input checked="" type="checkbox"/> 10m	<input type="checkbox"/> 15m/pe					
<input type="checkbox"/> Teach									
<input checked="" type="checkbox"/> Prepare						7	70	4	AM PM
19. Feeding									
<input type="checkbox"/> Cut Food				<input type="checkbox"/> 5m/pe					
<input type="checkbox"/> Help With Feeding				<input type="checkbox"/> 15m/pe					
<input checked="" type="checkbox"/> Encouragement			<input checked="" type="checkbox"/> 15m/pe	<input type="checkbox"/> 15m/pe	✓	7	105	4	AM/PM
<input type="checkbox"/> Tube				<input type="checkbox"/> 15m/pe					
<input type="checkbox"/> Record Intake				<input type="checkbox"/> 5m/pe					
SUB Total Time							585		

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VII. RECOMMENDED PLAN OF CARE: Indicate The Personal Care Services Required By The Client, Using The Following Codes To Identify The Providers.

- Key:**
- | | | |
|--------------------|---------------------|--------------------|
| 1. Family Member | 4. Home Attendant | 7. Other - Specify |
| 2. Friend/Neighbor | 5. Home Health Aide | M = Minutes |
| 3. HouseKeeper | 6. Nurse | P.E. = Per Event |
- qd = Daily

TASK	Not Needed	Indep.	Client Assistance		Frequency		Total Weekly Time	Prov.	Time of Day
			Some	Total	Daily	Weekly			
Medication Activities 20 Medication <input checked="" type="checkbox"/> Prompting/Cueing <input type="checkbox"/> Bringing <input type="checkbox"/> Opening Container <input type="checkbox"/> Removing From Container <input checked="" type="checkbox"/> Providing Liquids			<input checked="" type="checkbox"/> 5m/pe	<input type="checkbox"/> 5m/pe		7	35	4	AM
21 Other									
22 Housekeeping Activities Level I Cases Level II Cases Beds <input checked="" type="checkbox"/> Make <input checked="" type="checkbox"/> Change				4 hr/wk 5.5 hr/wk	8 hr/wk 7 hr/wk	7	240	4	AM
23 Dust/Vacuum/Mop									
24 Dishwashing <input checked="" type="checkbox"/> Hand <input type="checkbox"/> Dishwasher									
25 Light Cleaning <input checked="" type="checkbox"/> Bathroom <input checked="" type="checkbox"/> Patient Room <input checked="" type="checkbox"/> Kitchen <input checked="" type="checkbox"/> Living room									
26 Laundry <input type="checkbox"/> Mending <input type="checkbox"/> Hand <input checked="" type="checkbox"/> Automatic Washer <input checked="" type="checkbox"/> Ironing									
27 Listing Needed Supplies (e.g., groceries)									
28 Other Activities Authorized Personal Errands <input checked="" type="checkbox"/> Grocery Shopping <input checked="" type="checkbox"/> Picking Up Prescriptions <input type="checkbox"/> Other									
SUB Total Time Total Time (Pages 4, 5 and 6)							275 1575		

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VIII. A. ENVIRONMENT

Are there any environmental problems in the apartment? No Yes If Yes, Explain:

Do environmental problems affect task times? No Yes If Yes, Explain:

B. SLEEP-IN FACILITIES

Describe facilities for a sleep-in home attendant N/A

Sleeping:

Cooking:

Space for personal belongings:

Privacy:

C. 1. Can the client ever be safely left alone in the home? Yes No If No, Explain:

2. Can the client provide access to the home? Yes No If No, who will provide access :

3. Is the client appropriate for home care? Yes No If No, Explain:

4. Is the client appropriate for inclusion in a Home Care Cluster? Yes No If No, Explain:

5. Is the client currently included in a Home Care Cluster? Yes No

D. COMMENTS, SPECIAL INSTRUCTIONS, PLANS OR GOALS FOR CONTINUED SERVICE:

Pt. is a [redacted] year old female, lives alone with unsteady gait and diminished endurance. Ordered cane & safety equipment. Instructed on fall prevention-adequate lighting, clear pathway, reduce clutter, change positions slowly. Pt only able to prepare light meals, pt reports usually skips meals and eats 1 large meal a day. Pt. needs assistance with ADL's, grocery shopping, meal preparation, laundry, housekeeping & escorting to appts.

Month next visit to be made:

Nurse Name:

[redacted]

Nurse Signature:

[redacted]

Date of this Visit:

Agency: HHC
Health & Home Care

Telephone Number:

347 [redacted]

CLIENT'S NAME [REDACTED]

M27R ADDENDUM FOR CENTRAL CONVERSION UNIT

Please provide the following information concerning social supports/ environmental information:

HOUSING: Does the client live in an Apt. Private house Senior housing
Enriched Housing Adult Home Number of rooms _____ Pets in home? YES NO
Housing condition: Poor Fair Good
Can client communicate in English? If not, language spoken _____

Is there sufficient room and a bed for sleep-in HA Yes No

SUPPORT SYSTEMS: (Include anyone living in the home as well as outside the home)

NAME: [REDACTED] RELATIONSHIP: daughter (has [REDACTED])

ADDRESS: New York TELEPHONE NO. 347 [REDACTED]

SCHEDULE OF CARE: several times a week TASK(S) PERFORMED: on occasion meals/shopping psychosocial support

If employed, employment schedule: _____ Work Telephone No. _____

NAME: [REDACTED] RELATIONSHIP: sister

ADDRESS: New York TELEPHONE NO. [REDACTED]

SCHEDULE OF CARE: (1x) week TASK(S) PERFORMED: Psychosocial Support

If employed, employment schedule: _____ Work Telephone No. _____

Other Relatives/Significant Others:

Name _____ Address _____
Relationship _____ Telephone No. _____
Name _____ Address _____
Relationship _____ Telephone No. _____

ABILITY TO DIRECT/MANAGE FINANCIAL AFFAIRS:

Is client able to direct a home care worker? Yes No Manage Finances? Yes No

If the answer to either or both of these questions is "No," give the name, relationship, address, and telephone number of the person(s) who will assume each responsibility.

If you have any additional comments please write them on the back of this form.

PERSONAL EMERGENCY RESPONSE SERVICES (PERS) EVALUATION FORM

Client's Name [REDACTED] SS# [REDACTED] CASA/Office _____

1. Does the client have a functioning telephone with a private line? YES NO If YES, continue; if NO, STOP HERE - Client NOT appropriate for PERS.
2. Is the client alert and self-directing, (i.e., he/she is capable of making choices about the activities of daily living, understands the impact of these choices and assumes responsibility for the results of these choices) and mentally capable of understanding when to activate the PERS, knowing how to activate the PERS and capable of activating the PERS? After evaluating the appropriate sections of the assessment documents, would the client be able to activate the PERS equipment effectively?
 YES NO If YES, continue; if NO, STOP HERE - Client NOT appropriate for PERS.
3. Does the client have sufficient informal caretakers such as family and friends that are directly and continuously available to monitor his/her health and safety?
 YES NO If YES, STOP HERE - Client NOT appropriate for PERS.
4. Can the client communicate his or her need for help to the PERS monitoring agency? The following questions help determine whether the client meets these eligibility criteria:
 - a. Can the client verbally communicate with the PERS monitoring agency by speaking basic English? YES NO
 - b. If NO, can the client verbally communicate with the PERS monitoring agency by use of a language translation service (e.g. Language Line) if such service is available to the client? YES NO If a and b are NO, STOP HERE.
 - c. Does the client have a physical impairment (review the appropriate sections of the assessment documents) which may impede the ability to hear the speaker device, speak audibly into the PERS speaker, or reach or push the PERS button?
 YES NO If YES, describe this impairment.

5. Does the client have a medical condition, disability or impairment that may require the client to summon emergency assistance if unattended? Exclude those situations where an aide would meet the needs of the client. (Review the appropriate sections of the assessment documents.) YES NO If YES is checked, describe the medical condition.

6. After evaluating the client's physical, emotional and cognitive capacities, can the client activate a PERS? YES NO

[REDACTED]
Name and Title of PERS Reviewer _____

Date of PERS Review _____ Telephone # (347) [REDACTED]

Agency of Reviewer HHC Health & Home Care