NURSE'S ASSESSMENT VISIT REPORT

Field Office:	Case Manager:
1A. Client's Name: Birthdate:	☐ If Mutual Case, other Client's Name: S.S # — —
Address: Apt. # Floor:	Social Security # ________ Medicaid # ________ Medicare ☐ Yes ☐ No Medicare # ________
ASSESSMENT AGENCY: ☐ Home Attendant ☐ Housekeeper ☐ Home Health Agency ☐ Other ________ Billable Hours Per Week: ______ Authorized Hours Per Week: ______	Recommendation for Authorization of Services (in hours) ________ ☐ Start ☐ Continue ☐ Increase Tasks ☐ Deny ☐ Decrease Tasks ☐ Discontinue
PRESENT AT INTERVIEW: ☐ HA ☐ HK ☐ HHA ☐ Relative/Friend Source of Information:	RECOMMENDED LEVEL OF CARE ☐ Home Attendant ☐ Home Health Aide ☐ Housekeeper ☐ Other ________
Contact Person: Telephone #:	PURPOSE OF VISIT: ☐ Initial ☐ Reassessment ☐ Change
B. DIAGNOSIS: ICD-9 CODE If Available Primary: Secondary:	Significant Symptoms: Vital Signs:
CLIENT PRIMARY MEDICAL PROVIDER: Name: Telephone #	Regularly Scheduled Appointments-Day/Time-Frequency

IIA.

IMPAIRMENTS:	YES	NO	COMMENTS:
Speech	☐	☐	________
Dom. Hand/Arm	☐	☐	________
Other Hand/Arm	☐	☐	________
Lower Extremities	☐	☐	________
Cardiac Function	☐	☐	________
Respiratory Function	☐	☐	________
Obesity	☐	☐	________

ADDITIONAL FUNCTIONAL IMPAIRMENTS

B. BLADDER CONTROL	BOWEL CONTROL
☐ Continent ☐ Sometimes Incontinent ☐ Totally Incontinent ☐ Catheter Indicate Type ☐ Indwelling ☐ Texas Frequency: Urgency:	☐ Continent ☐ Sometimes Incontinent ☐ Totally Incontinent ☐ Ostomy Frequency: Urgency:

C. SIGHT:	HEARING:
☐ Total Blindness ☐ Legally Blind ☐ Glasses ☐ Contact Lenses	☐ Total Deafness ☐ Hearing Aid ☐ Lip Reading ☐ Can Interpret Loudness

NURSE'S ASSESSMENT VISIT REPORT

III. A. MOBILITY	Can Indep.	Can W/ Mech Aid	Can W/Aid of Person	Can-not
Walk or Wheel Inside				
Walk or Wheel Outside				
Get Up From Seated Position				
Get Up From Bed				
Transfer To Commode				
Transfer To Wheelchair				
Use Bedpan				

B. CLIENT ENDURANCE

- ☐ Tolerates Distances(250Ft +)
- ☐ Needs Intermittent Rest
- ☐ Barely Tolerates Short Activities
- ☐ No Tolerance

TELEPHONE USAGE

Is Client Able to Use Telephone

☐ Yes ☐ No, Explain

Does Client have a Personal Emergency Response System

☐ Yes ☐ No

C. CLIENT PREFERENCES FOR SERVICE HOURS AND ACTIVITIES: Use 24:00 Hour Clock

Rise Time ____:____
Breakfast ____:____
Bathing ____:____
Lunch ____:____
Dinner ____:____
Bedtime ____:____

D. CLIENT STATUS VARIATIONS DURING DAY

Include Any Peak Periods Of Functioning(e.g. Early Or Later In Day)

IV. A. MENTAL STATUS	YES	NO	COMMENTS
Oriented To Time, Person, Place	☐	☐	
Alert	☐	☐	
Able To Learn	☐	☐	
Able To Direct Worker	☐	☐	
Able To Manage Affairs	☐	☐	
Impaired Recent Memory	☐	☐	
Agitated	☐	☐	
Wanders If Unsupervised	☐	☐	
Depressed	☐	☐	
Anxious	☐	☐	

B. JUDGEMENT:	Appropriate	Fair	Inappropriate
What If Your Home Attendant Could Not Get Here	☐	☐	☐
What Would You Do If There Was A Fire While You Were Alone?	☐	☐	☐
What Would You Do If You Were Alone And You Got Chest Pain That Would Not Go Away?	☐	☐	☐
If Someone Rings Your Bell, What Do You Do?	☐	☐	☐

If Any Evidence Of The Following, Please Describe. Include Source Of Information And Indicate Action Taken And Recommended Follow-up:

- ☐ Verbally Abusive
- ☐ Physically Assaultive
- ☐ Suicidal Ideation
- ☐ Self-Endangering Behavior
- ☐ Known Psychiatric Disorder

NURSE'S ASSESSMENT VISIT REPORT

V. FUNCTIONAL AIDS

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? Have They Been Ordered? ☐ Yes ☐ No

Name of Supplier:

VI.

A. SKILLED NEEDS: Does Client Need Any Of The following? ☐ Yes ☐ No

If Yes, Specify Frequency and Provider

	Frequency	Provider
Decubitus Care		
Sterile Dressings		
ROM/Therapeutic Exercises		
Enema		
Ostomy Care		
Oxygen Administration		
Respiratory Therapy		
Catheter Irrigation/Insertion		
Tube Irrigation		
Tube Feeding		
Suctioning		
Monitor Vital Signs		
Other :		

B. ADDITIONAL SERVICES/REFERRAL: Indicate Whether The Client Should Be Referred For, Or Is Receiving The Following:

	ReferralNeeded		Receiving Services	
	☐ Yes	☐ No	☐ Yes	☐ No
Psychiatric Evaluation	____	____	____	____
Rehabilitation Therapy	____	____	____	____

Other:

C. CURRENT MEDICATIONS

Medication	Dosage	Frequency	Route	Can Client Self Administer? ☐ Yes	☐ No

Does Medication Need To Be Prepared For Client? ☐ Yes ☐ No

If Yes, Who Will Prepare? ____________________

COMMENTS:

Human Resources Administration
Home Care Services Program

NURSE'S ASSESSMENT VISIT REPORT

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
2. Friend/Neighbor
3. HouseKeeper
4. Home Attendant
5. Home Health Aide
6. Nurse
7. Other - Specify

M = Minutes
P.E. = Per Event
qd= Daily

PERSONAL CARE ACTIVITIES	Not Needed	Indep.	Client Assistance Some	Client Assistance Total	Frequency Daily	Frequency Weekly	Total Weekly Time	Prov.	Time of Day
1. Bathing									
☐ Bed									
☐ Tub									
☐ Chair									
☐ Shower									
☐ Sponge			10m/qd	20m/qd					
2. Dressing			10m/qd	15m/qd					
3. Grooming									
☐ Soak Hands & Feet									
☐ Lotion On Skin									
☐ Clean And File Nails									
☐ Mouth Care									
☐ Teeth									
☐ Dentures									
☐ Comb, Brush Hair									
☐ Shampoo									
☐ Shaving			10m/qd	15m/qd					
4. Toileting									
☐ Toilet									
☐ Commode/Bedpan									
☐ Diaper			30m/qd	60m/qd					
5. Transferring From ______ To									
☐ Motor Lift (per event)				☐ 15m					
☐ Slide Board									
☐ Pivot (per event)			☐ 5m	☐ 5m					
Length Of Time Can Sit Up: ____									
6. Mobility									
☐ Indoors			☐ 20m/qd	☐ 20m/qd					
☐ Outdoors			☐ 120m/wk	☐ 120m/wk					
SUB Total Time									

NOTE: If you indicate "some" or "total" assistance with ambulating, transferring, or toileting, explain the assistance needed below. If assistance with these tasks is unscheduled, indicate the span of time over which the assistance of a home attendant is required ______

COMMENTS:

NURSE'S ASSESSMENT VISIT REPORT

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 Some	Client Assistance Total	Frequency Daily	Frequency Weekly	Total Weekly Time	Prov.	Time of Day
7. Prepare for Bed			☐ 20m/qd	☐ 30m/qd					
8. Medical Supplies/ Equipment: Help in Using (e.g. Walker)									
9. Dressing: (per event)									
☐ Change Nonsterile Dressing			☐ 10m/pe	☐ 10m/pe					
☐ Reinforce Dressing			☐ 10m/pe	☐ 10m/pe					
10. Stable Colostomy Care (per event)			☐ 15m/pe	☐ 15m/pe					
11. Foley Catheter Care (Empty Bag/Wash Area)				☐ 10m/pe					
12. Texas Catheter Care				☐ 10m/pe					
13. Bedbound Positioning/Turning				☐ 10m/pe					
14. Escort - ☐ Stay with Client									
15. Prepare For Day Care Or Special Treatment (e.g. Dialysis)									
16. Other									
Nutritional Activities 17. Meal Preparation			☐ 30m/qd	☐ 60m/qd					
☐ Breakfast									
☐ Lunch									
☐ Dinner									
☐ Snack(s)				☐ 5m/pe					
18. Special Diet				☐ 15m/pe					
☐ Teach									
☐ Prepare									
19. Feeding									
☐ Cut Food				☐ 5m/pe					
☐ Help With Feeding				☐ 15m/pe					
☐ Encouragement			☐ 15m/pe	☐ 15m/pe					
☐ Tube									
☐ Record Intake				☐ 5m/pe					
SUB Total Time									

NURSE'S ASSESSMENT VISIT REPORT

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
2. Friend/Neighbor
3. HouseKeeper
4. Home Attendant
5. Home Health Aide
6. Nurse
7. Other - Specify

M = Minutes qd = Daily
P.E. = Per Event

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

Human Resources Administration
Home Care Services Program

NURSE'S ASSESSMENT VISIT REPORT

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

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:

Month next visit to be made: | Nurse Name: | Nurse Signature: | Date of this Visit:

Agency: | Telephone Number: