

Nursing Assessment for Home Care

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: ADAP
 ID Number: 555- _____ Social Security Number: _____
 Contact Person (Name & Relationship): _____
 Contact Phone (Day-time): _____ *Please submit release to allow Program contact.*

Living Situation:

Dwelling: Apartment House Other: _____ Floor: _____ # of Rooms: _____ Elevator: Yes No
 Lives alone: Yes No Identify all individuals living in the home: _____
 List the services, hours and days they are available and able to assist with care giving: _____

Hospitalization:

Hospital Name: _____ Address: _____
 Hospitalized: From: _____ To: _____ Diagnoses: _____ Hospital Contact: _____
 Phone: _____

Patient Status:

Is patient alert? Always Sometimes Never
 Can patient direct a home care worker? Yes No
 If no, who is responsible for directing home care workers?
 Name/Relationship: _____
 Patient Height: _____ Patient Weight: _____
 Recent significant weight loss? Yes No If Yes, amount lost: _____

Impairments:

Sensory:

	None	Partial	Total
1. Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Sight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Muscular/Motor:

	None	Partial	Total
1. Hand/Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular / Respiratory:

	None	Partial	Total
1. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe impact on functional ability.

- Does patient have history of tuberculosis? Yes No Pulmonary Extra pulmonary
- Did patient complete therapy? Yes No
- Does patient currently have tuberculosis? Yes No Pulmonary Extra pulmonary
- Is patient currently on tuberculosis prophylaxis? Yes No Hx of TB prophylaxis Yes No
- Last documented PPD: Date and result _____ Anergy results if available: _____
- If on tuberculosis treatment, are there 3 negative AFB? Yes No Negative chest x-ray Yes No

Nursing Forms 2015

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