

Initial Assessment Report

Applicant Name (last, first)	DOB
	CIN
Gender	Referral Source

Visit Summary

Purpose of Visit:	<input type="checkbox"/> Level of Care assessment <input type="checkbox"/> other:
Visit Location:	<input type="checkbox"/> Home <input type="checkbox"/> Facility (type: <input type="checkbox"/> acute, <input type="checkbox"/> rehabilitation, <input type="checkbox"/> NF B <input type="checkbox"/> NF A <input type="checkbox"/> RCFE) <input type="checkbox"/> ADHC <input type="checkbox"/> other:
Persons present:	
Information provided by:	
Comments:	

Home Safety Review

n/a. Home was not assessed.

Home Environment	<input type="checkbox"/> apartment <input type="checkbox"/> single family residence <input type="checkbox"/> condominium <input type="checkbox"/> mobile home <input type="checkbox"/> rented room <input type="checkbox"/> other:		
	<input type="checkbox"/> single story <input type="checkbox"/> multi-level bedrooms, bathrooms		
	<input type="checkbox"/> own bedroom <input type="checkbox"/> shares bedroom with <input type="checkbox"/> other:		
	Total # of entrances/exits: _____ How many are wheelchair accessible? _____		
	Lives alone? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If no, list other residents in the home and their relationship to the applicant:		
	Is there room for the storage of medical equipment and supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain the comments		
	Are there pets?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify type, quantity, and name (s) of caretaker:

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	Yes	No*
Is there a home/safety evaluation for this residence?	<input type="checkbox"/>	<input type="checkbox"/>
Is the home environment adequate for the provision of current services?	<input type="checkbox"/>	<input type="checkbox"/>
Are the utilities functional?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a fire extinguisher present?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a smoke detector & carbon monoxide detector present?	<input type="checkbox"/>	<input type="checkbox"/>
Is the home free from pests?	<input type="checkbox"/>	<input type="checkbox"/>
Is there an emergency evacuation plan?	<input type="checkbox"/>	<input type="checkbox"/>

*Please explain any No answers in the comments

Comments:

Medical History

Medical History:	
MD visit:	
Last ER visits:	
Last hospitalization:	

Allergies: Yes No If yes, please state:

Immunization(s) current: Yes No

Comments:

Review of Systems

Height/Length: _____ Weight: _____ Date: _____ Is the weight stable? Yes No
 Has the M.D. been notified of significant changes? Yes No

Neurological:

Within normal limits.

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Cognitive Functioning:	<input type="checkbox"/> awake/alert <input type="checkbox"/> lethargic <input type="checkbox"/> disoriented <input type="checkbox"/> comatose/non-responsive <input type="checkbox"/> Altered mental status or memory loss requiring supervision <input type="checkbox"/> Unable to understand spoken language (not related to a language barrier) <input type="checkbox"/> Unable to express needs or ideas (not related to a language barrier)
	Orientation: <input type="checkbox"/> person <input type="checkbox"/> place <input type="checkbox"/> time <input type="checkbox"/> situation
	Memory - short-term intact: <input type="checkbox"/> Yes <input type="checkbox"/> No long-term intact: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Decision making ability: <input type="checkbox"/> independent <input type="checkbox"/> impaired; if impaired-please identify authorized representative (AR):
MSQ score:	MMSE score: and/or SLUMS score:

Pain n/a <input type="checkbox"/>	location:		frequency:		
	treatment:				
	Date of last PRN medication:				

Seizure activity n/a <input type="checkbox"/>	Are they controlled with medications?		<input type="checkbox"/> Yes <input type="checkbox"/> No; if no please provide date of most recent seizure episode:		
	Type:		Frequency:		
	Description:				
	Medications/Treatment:				
	Date of last PRN medication:				

Vision Impairment n/a <input type="checkbox"/>	<input type="checkbox"/> Partially impaired needs or wears corrective lenses				
	<input type="checkbox"/> Severely impaired/legally blind				
	<input type="checkbox"/> Unable to assess				

Hearing Impairment n/a <input type="checkbox"/>	<input type="checkbox"/> Partially impaired/hard of hearing				
	<input type="checkbox"/> Uses hearing aid in <input type="checkbox"/> left ear <input type="checkbox"/> right ear				
	<input type="checkbox"/> Severely impaired/deaf <input type="checkbox"/> able to lip read				
	<input type="checkbox"/> Unable to assess				

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Speech Impairment n/a <input type="checkbox"/>	<input type="checkbox"/> Minimal difficulty in speaking due to tracheostomy or in expressing ideas and needs.
	<input type="checkbox"/> Moderate difficulty, speaks in phrases short sentences
	<input type="checkbox"/> Severe difficulty in expressing basic ideas or needs. Uses single words or short phrases.
	<input type="checkbox"/> Aphasic. Unable to express basic needs, but is not comatose or unresponsive
	<input type="checkbox"/> Nonresponsive or comatose

Language & Communication Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary language, if other than English:		
	Requires language interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Uses: <input type="checkbox"/> American Sign Language <input type="checkbox"/> gestures <input type="checkbox"/> sounds <input type="checkbox"/> speech generating and/or other communication device		
	Speech Therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, frequency:

please document any other issues in the comments section

Comments:

DME/Medical Supplies: (please list)

DME/Medical Supply Issues:

Respiratory:

Within normal limits

Medical Gases n/a <input type="checkbox"/>	O ₂ @ l/min via <input type="checkbox"/> continuous or <input type="checkbox"/> prn If prn, last used:		
	Humidification: If used, frequency:		
	Room air mist If used, frequency:		

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Airway Clearance Issues n/a <input type="checkbox"/>	Able to cough and expectorate secretions: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Uses in-exsufflator to stimulate cough: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Requires suctioning: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of suctioning: <input type="checkbox"/> oral <input type="checkbox"/> nasal <input type="checkbox"/> tracheal Frequency: _____ Equipment used: <input type="checkbox"/> suction machine <input type="checkbox"/> bulb syringe
	Secretions (please describe):
	Chest PT: If used, frequency:

Respiratory Treatments n/a <input type="checkbox"/>	Medication & frequency: Nebulizer <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, administer by whom:
	Date of last PRN & reason:

Tracheostomy n/a <input type="checkbox"/>	Type & Size: _____ Date last changed: _____ and by whom: _____
	Frequency of tracheostomy care:
	How the trach cleaning is done: <input type="checkbox"/> sterile or <input type="checkbox"/> clean technique
	Is the tracheostomy stoma clean and free from complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please describe:

Bi-Level Positive Airway Pressure (Bi-PAP) n/a <input type="checkbox"/>	Frequency of use:
	Individual able to connect self to Bi-PAP? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Back-up power:

Continuous Positive Airway Pressure (CPAP) n/a <input type="checkbox"/>	Frequency of use:
	Individual able to connect self to CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Pulse oximeter n/a <input type="checkbox"/>	Frequency of use:
	# of desaturations: in a <input type="checkbox"/> day <input type="checkbox"/> week.
	Interventions:
	Date of last desaturation & intervention:

Person who cleans & cares for equipment: _____

Date of last upper respiratory infection or pneumonia:
Treatment:

Number of upper respiratory infections or pneumonia within the last 6 months:

please document any other issues in the comments section

Comments:

DME/Medical Supplies: (please list)

DME/Medical Supply Issues:

Cardiovascular:

Within normal limits

Cardiovascular medications n/a <input type="checkbox"/>	Cardiovascular medications: (Please list below and state the reason for the medication)
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Pacemaker n/a <input type="checkbox"/>	How often is it checked? Date last checked:
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Pulse and BP monitored: <input type="checkbox"/> Yes <input type="checkbox"/> No How often is it checked: By whom:
If yes, what is the most recent pulse and BP: date taken:
Intake & Output monitored: <input type="checkbox"/> Yes <input type="checkbox"/> No How often is it checked: By whom:

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Central line n/a <input type="checkbox"/>	Location:
	Site care:
	Person(s) responsible for central line care:
	Is the insertion site clean and free from complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please describe:
	Is the line used for intravenous or infusion therapy (excluding TPN): <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what is the frequency? . Who administers the infusion?

please document any other issues in the comments section

Comments:

DME/Medical Supplies: (please list)

DME/Medical Supply Issues:

Genito-Urinary:

Within normal limits

Incontinent: Yes No If yes, please indicate type (s): Functional Overflow Stress Urge
(If yes, list the supplies and amount used **daily** in the DME/Medical Supplies section below.)

n/a <input type="checkbox"/>	<input type="checkbox"/> Indwelling Foley catheter <input type="checkbox"/> Suprapubic catheter size: Fr.
	Catheter last changed on by . It is changed .
	Catheter care frequency:
	Drainage bag changes & care:

n/a <input type="checkbox"/>	<input type="checkbox"/> Intermittent catheterizations Frequency: Performed by:
	Catheter size: Fr
	Technique used <input type="checkbox"/> clean <input type="checkbox"/> sterile

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n/a <input type="checkbox"/>	Other urinary diversion or collection device (please specify below):
n/a <input type="checkbox"/>	Care/treatment ordered for urinary diversion/collection device:

n/a <input type="checkbox"/>	Bladder irrigation: Frequency: Irrigating solution: Performed by:
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Dialysis n/a <input type="checkbox"/>	<input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Hemodialysis Frequency:	
	Dialysis performed at:	Transported by:

Date of last urinary tract infection: _____ Treatment:

Does the participant have menses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a

please document any other issues in the comments section

Comments:

DME/Medical Supplies: (please list)

DME/Medical Supply Issues:

Gastrointestinal:

Within normal limits

Oral Nutritional Intake n/a <input type="checkbox"/>	<input type="checkbox"/> Regular diet <input type="checkbox"/> Other (specify):
	<input type="checkbox"/> Able to independently feed self <input type="checkbox"/> Requires meal set-up, intermittent assistance or supervision from another person <input type="checkbox"/> Unable to feed self
	<input type="checkbox"/> Receives supplemental nutrients through a nasogastric tube or gastrostomy tube in addition to oral feedings

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Enteral Nutrition n/a <input type="checkbox"/>	Feeding formula, frequency & rate:
	<input type="checkbox"/> feeding pump <input type="checkbox"/> bolus feeding
	Residual checked: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount:
	<input type="checkbox"/> Gastrostomy tube size: Fr <input type="checkbox"/> MIC-KEY button size: Fr <input type="checkbox"/> Jejunostomy tube size: Fr <input type="checkbox"/> Nasogastric tube size: Fr
	Button/Tube last changed on _____ by _____ . <input type="checkbox"/> It is changed . <input type="checkbox"/> There is no regular schedule for changing the tube.
	Site Care:
	Frequency:
	Is the button/tube insertion site clean and free from complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please describe:

Parenteral Nutrition n/a <input type="checkbox"/>	<input type="checkbox"/> TPN <input type="checkbox"/> Lipids Infusion rate: cc/hr over hours via .
	Administered by:

Elimination	Bowel pattern: <input type="checkbox"/> normal <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea
	Frequency:
	Bowel incontinence: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Bowel program: <input type="checkbox"/> Yes <input type="checkbox"/> No
	if yes, bowel program using:
	if digital stimulation/disimpaction is ordered: frequency performed by
	Ostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type:
	Ostomy care: Please describe

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Endocrine Disorders <input type="checkbox"/> n/a	Diabetes Mellitus treated with: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral antidiabetic agents <input type="checkbox"/> Diet only
	Medication:
	Blood Glucose monitoring: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, frequency: _____ By whom: _____
	If yes, blood glucose range within the last month: _____ HgbA1C level: _____ Date: _____
	Sliding scale coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, frequency: _____ By whom: _____
Thyroid issues: <input type="checkbox"/> Yes <input type="checkbox"/> No medication: _____	

please document any other issues in the comments section

Comments:

DME/Medical Supplies: (please list)

DME/Medical Supply Issues:

Integumentary:

Within normal limits. Skin is intact.

please document any issues in the comments section

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	Stages:	Description: # of ulcers, location, size, healing status*			
		# of ulcers 1	# of ulcers 2	# of ulcers 3	# of ulcers 4 or more
Decubitus Ulcers n/a <input type="checkbox"/>	I				
	II				
	III				
	IV				
	Wound care and treatment ordered:				
	Frequency of care:				
	Care performed by:				
	Therapeutic Anti-Decubitus Mattresses and Bed Products used:				
	Number of available turning surfaces:				
	*Healing status: fully granulating, early/partial granulation, not healing				

Skin lesions, stasis ulcers, wounds, or other skin integrity issues n/a <input type="checkbox"/>	Location:	
	Description: (include location, size, healing status)	
	Wound care/treatment: (include frequency)	
	Care performed by:	

please document any other issues in the comments section

Comments:

DME/Medical Supplies: (please list)

DME/Medical Supply Issues:

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Musculoskeletal:

Within normal limits

Motor function impairment n/a <input type="checkbox"/>	Able to move all extremities: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, describe limitations:
	Able to turn and position self in bed: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, performed by whom: frequency:
	Weakness:
	Contractures:
	Spasticity:
	Flaccid:

Ambulation	<input type="checkbox"/> Independent <input type="checkbox"/> Requires use of an assistive device (<input type="checkbox"/> cane <input type="checkbox"/> walker <input type="checkbox"/> crutches) <input type="checkbox"/> Non-ambulatory
	Gait steady: <input type="checkbox"/> Yes <input type="checkbox"/> No Fall Risk: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide date of last fall and injury sustained if any:
	Requires supervision or assistance of another person assistance to negotiate stairs, steps or uneven surfaces: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Requires supervision or assistance of another person at all times: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ambulation issues: please describe

Mobility n/a <input type="checkbox"/>	manual wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No able to wheel self independently: <input type="checkbox"/> Yes <input type="checkbox"/> No
	power wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No able to use power chair independently: <input type="checkbox"/> Yes <input type="checkbox"/> No
	wheelchair usage (frequency and duration)
	wheelchair issues:
	(Empty space for notes)

Transfer issues n/a <input type="checkbox"/>	Transfers with minimal assistance or with use of an assistive device: <input type="checkbox"/> Yes <input type="checkbox"/> No.
	Assistive device:
	Able to bear weight and pivot: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Must be physically lifted by nurse/primary caregiver: <input type="checkbox"/> one person <input type="checkbox"/> two person.
	Hydraulic lift: <input type="checkbox"/> Yes <input type="checkbox"/> No

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Orthotics and/or prosthetics n/a <input type="checkbox"/>	type:	
	frequency:	
	compliance:	

Therapies n/a <input type="checkbox"/>	Physical Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No frequency:	
	Is there a home treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Last reviewed by therapist:	
	Progress towards treatment goals:	
	Occupational Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No frequency:	
		Is there a home treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Last reviewed by therapist:
Progress towards treatment goals:		

Restraints n/a <input type="checkbox"/>	type:	
	frequency:	
	reason:	

please document any other issues in the comments section

Comments:

DME/Medical Supplies: (please list)

DME/Medical Supply Issues:

Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL)

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Function	Independent	Requires assistance	Dependent	Comments
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Telephone usage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Housekeeping (cooking, cleaning, laundry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medication Administration and Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Equipment/Supply Management:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Transportation:	<input type="checkbox"/> Independent uses public transportation (bus, van service, etc.) or drives own car <input type="checkbox"/> Travels using private auto driven by another <input type="checkbox"/> Needs to be accompanied by another <input type="checkbox"/> Requires Non-emergency medical transportation <input type="checkbox"/> Other:
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please document any other issues in the comments section

Comments:

DME/Medical Supplies: (please list)

DME/Medical Supply Issues:

Psychosocial

Primary Caregiver: Relationship to candidate/participant:

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Back-up Caregiver: Relationship to candidate/participant:

	Yes	No*	n/a
Is there a back-up plan if there is no primary or backup caregiver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the back-up plan adequately address the health and safety needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the participant, family and/or legal guardian coping with current services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the participant, family, and/or legal guardian satisfied with how the participant's care is currently being delivered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are the candidate/participant's preferences for care considered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Please explain any No answers in the comments

Comments:

	Yes	No
Ask the applicant/participant/primary caregiver (as appropriate):		
Are there issues or concerns regarding neglect, exploitation or abuse?*	<input type="checkbox"/>	<input type="checkbox"/>
Is the candidate/participant/primary caregiver aware of how and to whom they should report issues or concerns regarding neglect, exploitation or abuse?	<input type="checkbox"/>	<input type="checkbox"/>
If such events occurred, were the appropriate authorities notified? *	<input type="checkbox"/>	<input type="checkbox"/>

*If Yes, please explain in the comments

Comments:

Employed: Yes No If yes, type of work: # of hours worked:

School: Yes No name of school: # of hours attended:

Comments:

Other Services

IHSS	Hours:		County:	
n/a <input type="checkbox"/>	Comments:			

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OHC n/a <input type="checkbox"/>	Plan:	
	Services:	

Comments:

Justification for NF-B Level of Care

Based upon the information contained in this report,	meets <input type="checkbox"/>	does not meet <input type="checkbox"/>	the NF-B Level of Care. Level of Care (LOC) determination: NF-B <input type="checkbox"/>
LOC justification:			

Registered Nurse	<hr style="width: 80%; margin: 0 auto;"/> signature	Date report completed:
	printed name	