E-CHAT For Users in New Mexico

*Individual Name: ______________________________  Time zone: __________________________
*Entered By: ________________________________  * Date: ______________  * Time: _______ am/pm

Reason for Assessment: □ Annual Assessment/ISP  □ New Admission/Agency Transfer  □ Change of Condition
□ Hospital Discharge □ Hospital Discharge for Aspiration Pneumonia □ Quarterly Nursing Assessment □ Other

ISP Effective Date: From: __________.  To: __________.
ISP Meeting Date: __________.  Date of Assessment: __________.

Diagnoses and Conditions

1. Active Diagnoses:

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>ICD-9 /DSM-4 /Other</th>
<th>Axis</th>
<th>DSM-5</th>
<th>Description</th>
<th>Diagnosis Date</th>
<th>Diagnosed By</th>
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Other Medical Information

Historical / Inactive Diagnoses or Conditions: _____________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
1.a Comments: _____________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Allergies

2. Allergies: _____________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

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2.a Are there any known allergies to food, environment or drugs?  □ No  □ Yes
2.b Is there a known history of anaphylactic reaction?  □ No  □ Yes

2.c Comments: __________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Medications:

3. Medications:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose Form</th>
<th>Strength</th>
<th>Give Amount / Quantity</th>
<th>Frequency</th>
<th>Indication / Purpose</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Time Zone</th>
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3.a Medication Delivery Supports:  □ Self-Administration of Medications  □ Self-Administration with Physical Assistance  □ Assistance with Medication Delivery by Staff  □ Medication Administration by Licensed or Certified Personnel

Receives routine injectable medication(s) by:
□ Agency licensed nurse or certified medication aide daily or multiple times per day
□ Agency licensed nurse or certified medication aide several times a week
□ Agency licensed nurse or certified medication aide at least once per month
□ Agency licensed nurse or certified medication aide at least annually or up to once per quarter
□ Self administration or biological family member at any frequency
□ Physician, PCP or clinic (loading of pump; intermittent long acting injections)

Nurse/IDT comments: __________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3.b Monitoring Effectiveness of Medications: __________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3.c Refusal of Medications, Treatments or Monitoring:  □ Never or rarely refuses  □ Frequent refusal or occasional refusal that has impact on health

3.d Comments: ________________________________________________________________________________
__________________________________________________________________________________________
Labs/Radiology:

4. Any abnormal lab work or radiology exams in the past year?  □ No  □ Yes

If Yes, Provide a synopsis of any abnormal lab or radiology finding and activities taken to follow up or address these issues: ________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

4.a Currently requires frequent lab tests or radiology exams routinely to manage, monitor or maintain health status.  □ No  □ Yes

4.b Comments: ____________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Utilization of Medical Services:

5. Scheduled visit to PCP in the past year: □ 1-4 times  □ 5-7 times  □ 8 or more times

5.a Urgent care or Emergency room visit in the past year: □ 0-2 times  □ 3-4 times  □ 5 or more times

5.b Number of medical hospitalizations in the past year: □ 0-1 time  □ 2-3 times  □ 4 or more times

5.c Number of psychiatric hospitalizations in the past year: □ 0-1 time  □ 2-3 times  □ 4 or more times

5.d Number of medical hospitalizations in the last 3 months: □ 0 time  □ 1 time □ 2 or more times

5.e Number of psychiatric hospitalizations in the last 3 months: □ 0 time □ 1 time □ 2 or more times

5.f Required Heimlich maneuver or abdominal thrusts to clear airway: □ 0 time □ 1 time □ 2 or more times

5.g Is there an existing diagnosis, a new diagnosis or a condition change that requires frequent medical follow up, treatment or monitoring (i.e. cancer, acute illness)?  □ No  □ Yes

If Yes, Describe: ________________________________________________________________

______________________________________________________________________________

__________________________________________________________________________

5.h Comments: ________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Vital Signs

6. Were vital signs taken at the time of this assessment? □ No  □ Yes

If Yes:  Temperature: ______________________________.  Pulse: ______________________________.

Respirations: ______________________________.  Blood Pressure: ______________________________.

6.a Pulse Oximeter readings ordered? □ N/A  □ No  □ Yes

If Yes: Most Recent Oximeter Reading: □ 02 < 90% □ 02 > or = 90% Date and Time: ____________.
6.b Comments: ____________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Height and Weight

7. Height: ___________ Feet ___________ Inch. Weight: ___________ lbs

7.a Has there been unplanned weight gain (> 5 lbs)?  □ No  □ Unknown  □ Yes
7.b Has there been unplanned weightloss?  □ No  □ Unknown  □ Yes

If Yes: □ Unplanned loss of less than 5% of total body weight in a 3-month period
       □ Unplanned loss of up to 10% (or higher) of total body weight or 10 lbs in a 6-month period

7.c BMI: ___________

7.d Comments: ____________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
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_________________________________________________________________________________________________

Nutrition

8. Does the individual receive a special diet?  □ No  □ Yes

Diet Order: □ Regular □ NPO □ Diabetic  Number of Calories: _______ □ High Calorie, Number of Calories: _______
□ Low Salt □ Low Fat □ Ketogenic □ Gluten Free □ Other: _______________________________

Diet Texture: □ Regular □ Chopped □ Mechanical Soft □ Pureed  □ Other: _______________________________

Fluid Consistency: □ Regular/thin liquid □ Nectar thickened □ Honey Thickened □ Pudding thickened □ Other: _______________________________

8.a Does individual require fluid restriction?  □ No  □ Yes
8.b Does individual require supports to assure adequate hydration or minimize risk of dehydration?
□ No supports □ Occasional supports □ Frequent – daily support

8.c Is intake and output monitoring ordered by a PCP/Specialist? □ No  □ Yes
If Yes: □ Intake only □ Output only □ Both Intake and Output

8.d Comments: ____________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
Tube Feeding/Enteral Nutrition

9. Does individual receive tube feeding or enteral nutrition?  □ No  □ Yes

Tube type:  □ NG  □ G Tube  □ G/J Tube  □ J Tube

Tube Details:  □ PEG  □ Mic-Key  □ Button/low profile  □ Balloon tip (foley)
□ Other: ________________________________________________________________

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Tube type:  □ NG  □ G Tube  □ G/J Tube  □ J Tube

Tube Details:  □ PEG  □ Mic-Key  □ Button/low profile  □ Balloon tip (foley)
□ Other: ________________________________________________________________

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Original tube placement date: __________________________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Tube last replaced: __________________________________________________________________________________
______________________________________________________________________
______________________________________________________________________

9. a Tube site information at time of assessment: □ Site clean and dry  □ Healthy pink stoma
 □ Reddened skin around stoma  □ Macerated skin around stoma  □ Retracted stoma  □ Retracted tube or button
 □ Leaking formula  □ Purulent drainage  □ Erosion at site  □ Fistula at site

Describe additional condition of tube and site, as well as any ongoing concerns: _____________________
____________________________________________________________________________
____________________________________________________________________________

9. b Risk for tube displacement: □ Never or rarely touches  □ Often touches or pulls  □ Pulls out tube

9. c Comments: __________________________________________
____________________________________________________________________________
____________________________________________________________________________

Aspiration Risk

10. Aspiration Risk as determined by Screening Tool:  □ Low  □ Moderate  □ High

10. a Comments: __________________________________________
____________________________________________________________________________
____________________________________________________________________________

Oral Dental

11. Level of assistance with oral care/hygiene: □ Independent  □ With some assistance  □ Extensive assistance, total dependence

11. a Status of oral care/hygiene: based on dental report or observation:  □ Good oral hygiene  □ Bad breath
 □ Fair oral hygiene  □ Poor Oral hygiene  □ Excessive plaque  □ Multiple cavities
Obvious decay  □ Broken teeth  □ Inflamed gums  □ Bleeding gums  
□ Periodontal disease  □ Loose teeth  □ Edentulous (no teeth)  □ Uses dentures or partial plates

11. b Comments: 
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Neurological Signs and Symptoms:

12. Is cerebral shunt in place? □ No □ Yes Date Inserted (If known) ____________________________
Is baclofen pump in place? □ No □ Yes Date Inserted (If known) ____________________________
Is vagal nerve stimulator (VNS) in place? □ No □ Yes Date Inserted (If known) ____________________________
Model or type (if known) ____________________________
Other devices or implants? □ No □ Yes Date Inserted (If known) ____________________________
Comments: ___________________________________________ 
____________________________________________________________________________________
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12.a Are signs and symptoms of recent neurological changes present? □ No □ Yes

12.b Is there a seizure disorder? □ No □ Yes □ Unknown

Types of seizures usually seen □ None □ Absence (petit mal) □ Atypical absence □ Atonic 
□ Clonic □ Febrile □ Focal □ Generalized □ Myoclonic (brief muscle jerking) 
□ Tonic-clonic (grand mal) □ Psychogenic □ Secondary Generalized □ Simple Partial □ Complex Partial 
□ Other: _______________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Frequency of seizures: □ History of seizures but no recent reports of seizure activity 
□ No seizures in the past year □ 1 seizure in the past year □ Several times per year □ Several times per month 
□ At least weekly □ Daily or multiple times per day □ Multiple times per hour 
Any change in the frequency of seizures over the last several months: □ No Change □ Yes 
If Yes: □ Increase □ Decrease 
Status epilepticus in last 12 months? □ No □ Yes
If Yes, Describe, include cause/trigger if known: ____________________________________________ 
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Comments: ___________________________________________ 
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12.c Is paralysis present? □ No □ Yes
If Yes:  □ Paraplegic  □ Quadriplegic  □ Hemiplegic Left  □ Hemiplegic Right

Describe:  

________________________________________________________________________________________
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12.d Diagnosis of autonomic dysreflexia?  □ No  □ Yes
If Yes, Describe:  

________________________________________________________________________________________
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________________________________________________________________________________________.

12.e Diagnosis of Alzheimer's Disease or other dementias?  □ No  □ Yes
12.f Other neurological disorders or events that may require planning?  □ No  □ Yes
If Yes, Describe:  

________________________________________________________________________________________
________________________________________________________________________________________
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12. g Comments:  

________________________________________________________________________________________
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Cardiac/ Circulatory/ Blood Disorders

13. Is there a known cardiac or circulatory condition (i.e. hypertension, heart valve disease, or conditions associated with specific syndromes)?  □ No  □ Yes
If Yes:  □ Cardiac/circulatory condition is stable on current treatment plan (medication, diet, activity level, and/or other interventions)  
□ Cardiac/circulatory condition is not stable or has resulted in limitations at work, home or leisure

13.a Is a pacemaker in place?  □ No  □ Yes
If Yes:  Date Inserted (If known): ____________________ Model or type (if known): _________________________

13.b Is an implantable cardioverter defibrillator (ICD) in place?  □ No  □ Yes
If Yes:  Date Inserted (If known): ____________________ Model or type (if known): _________________________

13.c Other cardiac disorders that may require planning?  □ No  □ Yes
If Yes, Describe:  

________________________________________________________________________________________
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13.d Are there any current blood/hematological disorders (such as anemia, leukemia, clotting, etc) that may require medications, monitoring or planning?  □ No  □ Yes
Endocrine

14. Has the individual been diagnosed with diabetes? □ No □ Yes If Yes: □ Type 1 □ Type 2

14.a Can individual independently complete all or part of their own blood glucose monitoring? □ No □ Yes □ N/A

14.b Can individual complete self-administration of insulin? □ No □ Yes □ N/A

14.c Does individual experience hypoglycemia? □ No □ Yes □ Irregular pattern of hypo/hyperglycemia

14.d A1c Levels: □ A1c levels not available □ A1c > 6 □ A1c = 6 or higher

14.e Diabetes Comments: _________________________________________________________________

Renal

15. Kidney/renal disorders that may require planning? □ No □ Yes

15.a Dialysis: any type □ No □ Yes If Yes: □ Peritoneal □ Hemodialysis

15.b Comments: _________________________________________________________________
Gastrontestinal

16. Is there a known gastrointestinal condition?  □ No  □ Yes
16.a Receives medication for reflux or GERD?  □ No  □ Yes
16.b Complains of or demonstrates signs/symptoms of reflux?  □ None □ Complains of □ Demonstrates
If Complains: □ Heartburn □ Indigestion □ Abdominal pain □ Vomiting
If Demonstrates (observed or reported): □ Biting hand □ Arching back □ Touching stomach
□ Food/formula in mouth □ Vomiting □ Coughing while lying down
16.c Has Celiac disease or gluten sensitivity?  □ No  □ Yes
16.d Constipation Management  □ No issues with constipation  □ Receives routine medications or treatments for constipation □ Regularly utilizes PRN medications or treatments (i.e. enema, suppository) for constipations □ Has had impaction or bowel obstruction in the last year
16.e Has diagnosis of PICA (history or active)?  □ No  □ Yes □ Unknown
16.f Comments:   __________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________

Bowel and Bladder

17. Bowel Function:  □ Continent  □ Sometimes incontinent  □ Always incontinent
Bladder Function:  □ Continent  □ Sometimes incontinent  □ Always incontinent
17.a Colostomy/Ileostomy:  □ No  □ Yes
If Yes: □ New colostomy/ileostomy (in the past year) □ Colostomy/ileostomy stable/no issues with management □ Individual exhibits challenging behavior that impacts colostomy/ileostomy care
Comments: 
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
17.b Other bowel and bladder concerns: □ None □ Reported or observed bleeding in urine □ Reported or observed rectal bleeding □ Urinary catheter - intermittent: □ Self □ Staff □ Urinary catheter - Texas or external □ Urinary catheter - Indwelling □ Suprapubic/ nephrostomy/ Indiana pouch □ Urinary retention or BPH □ Frequent Diarrhea □ Other: ____________________________
17.c Comments: __________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Reproductive Health

18. Is the individual sexually active? □ No □ Yes □ Unknown

Interested in information about birth control? □ No □ Yes

Interested in attending sexuality classes? □ No □ Yes

Gender (Women and Men):
Women Only (Choose all that apply): □ No reproductive health concerns □ Pregnant □ Menopausal □ Reported or observed abnormal vaginal bleeding or discharge □ Reported or observed abnormal breast lesions, lumps or discharge

Date of last Pap smear if ordered by a physician or description of other monitoring in place: ________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Date of last Mammogram if ordered by a physician or Description of other monitoring in place: ________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Men Only:

Date of last PSA if ordered by a physician or description of other monitoring in place: ________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

PSA ordered more than once a year? □ No □ Yes

18.a Cancer history requiring follow up care? □ No □ Yes

18.b Comments: ___________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Behavior Symptoms and Management

19. Has there been a recent change in behavior symptoms that may be caused by a medical condition? □ No □ Yes

If Yes, Describe: ___________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

19.a Numbers of psychoactive or other classes of medications that are intended to influence Behavior symptoms? □ None □ 1-2 medications □ 3-4 medications □ 5 or more medications

19.b Newly reported or observed sign of extrapyramidal symptoms (ESP) involuntary movement disorders? □ No □ Yes
19.c History of neuroleptic malignant syndrome? □ No □ Yes

Name of Medication (If known) __________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

19.d History of neuroleptic malignant syndrome? □ Never □ 1-5 □ 6-10 □ 11 or more

19.e Comments: ______________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Infection Control

20. Is the individual immunocompromised? □ No □ Yes

20.a Colonized or Infected with multidrug-resistant organism? □ No □ Yes

20.b Known chronic viral infection such as hepatitis or other blood borne pathogens? □ No □ Yes

20.c Other infectious process or disease required planning? □ No □ Yes
If Yes, Describe: _________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

20.d Comments: _________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Respiratory

21. Respiratory status requires routine or intermittent treatment or equipment: □ No □ Yes

Indicate all that apply: □ Cupping/Clapping/Postural Drainage □ Oxygen use via cannula or mask □ Oxygen use via trach
□ Oral and/or pharyngeal suctioning □ Tracheal suctioning □ Tracheotomy □ Ventilator □ Percussion Vest
□ Refuses oxygen use □ Other: __________________________________________________
________________________________________________________________________________
________________________________________________________________________________

If on oxygen, indicate number of liters: ______

Nebulizer treatments or inhalers □ No □ Yes If Yes, frequency: □ PRN □ At least weekly □ Daily/more often

Sleep Apnea: Has CPAP/BiPAP devices ordered: □ No devices Ordered □ Uses regularly □ Refuses to use

Other acute or chronic respiratory issues that may require planning? □ No □ Yes – Describe: _________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
21.a Comments: __________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________.

Communication / Vision / Hearing

22. Able to make need known?  □ Yes Verbal  □ Yes w/out devices  □ Yes w/ devices  □ No

22.a Known Visual impairment (Choose all that apply):  □ None  □ Uses glasses or contacts
□ Refuses glasses or contacts  □ Complete visual impairment or cortical blindness
□ Other: __________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

22.b Known Hearing Impairment (Choose all that apply):  □ None  □ Uses Aide(s)  □ Refuses aide(s)
□ Uses ASL, gestures or devices  □ Other: _____________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
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___________________________________________________________________________________________

22.c Comments: __________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Musculoskeletal / Neuromuscular

23. Musculoskeletal or neuromuscular disorders that may require planning?  □ No  □ Yes
Describe: __________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

23.a Fracture in the last year?  □ No  □ Yes – Status: ____________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
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___________________________________________________________________________________________
___________________________________________________________________________________________

23. b Spasticity or contractures require routine interventions to maintain positioning, minimize pressure and support comfort and safety  □ No  □ Yes

23.c Change or decline in functional ability in last year?  □ No  □ Yes

23.d Comments: __________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
Falls

24. Number of fall(s) in the last year?  □ None  □ 1-2 falls  □ 3 or more falls

Did any fall result in injury that required medical treatment in urgent care or emergency room?  □ No  □ Yes

24.a Comments:  __________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Pain

25. Currently experiencing pain?  □ No  □ Nonverbal and may be experiencing pain
   □ Yes  If Yes, specify:  □ Controlled with medication or treatment
           □ Partial or poor control with medication or treatment
           □ Not controlled with medication or treatment

25.a Nonverbal and may be experiencing pain:  □ Does not appear to be in distress; relaxed, not crying
   □ Occasionally grimaces; whimpers; restless or tense; able to calm or reassure
   □ Frequent grimace or frowns; obvious physical distress; may be rigid or jerking; crying, moaning, unable to
     comfort, hitting self or others, or unique actions known to be that person's way of communicating pain or distress

25.b Receives pain medication?  □ No  □ Self administers all pain medication
   □ Yes and requires assistance or administration of medication  □ If Yes, specify below:
     □ PRN 3 times per month or less  □ PRN 1 time per week  □ PRN 2 or more times per week
     □ PRN daily or several times per day

25.c Comments:  _________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Activity of Daily Living

26. Level of assistance with grooming/dressing:  □ Independent or minimal assistance
    □ Moderate assistance and/or requires adaptive equipment  □ Totally dependent

Level of assistance with hygiene/bathing:  □ Independent or minimal assistance
    □ Moderate assistance and/or requires adaptive equipment  □ Totally dependent

Level of assistance with transfer/mobility:  □ Independent or minimal assistance
    □ Moderate assistance and/or requires adaptive equipment  □ Totally dependent  □ Bedbound

Individual is non-ambulatory and prefers to spend majority of time on the floor  □ No  □ Yes

26.a Comments:  __________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Skin and Wound

27. Choose the applicable statement:

- Answer in above section for transfer/mobility was independent or minimal assistance and there is no known history of pressure ulcers
- Answer in above section for transfer/mobility was independent or minimal assistance and there is a known history of pressure ulcers
- Answer in above section for transfer/mobility was moderate assistance/requires adaptive equipment or totally dependent

Conditions (Choose all that apply):
- Underweight by standard
- Incontinent of bowel, bladder or both
- Shearing forces in bed or chair
- Contractures
- Fixed deformity (kyphosis/scoliosis)
- Neuropathy
- History of pressure ulcers (now healed)
- Altered consciousness (lethargic, difficult to rouse)

Open skin areas:
- None
- Pressure ulcers
- Vascular ulcers

Other open skin areas (surgical sites/cuts/lacerations/erosions):
- ________________________________
- ______________________________________
- ______________________________________
- ______________________________________

Treatments for open skin areas:
- N/A
- Routine treatments ordered (aseptic)
- Sterile Treatments
- Complex treatments ordered (wound vac, etc)

Other Skin Conditions?:
- No
- Yes

27.a Skin integrity: Individual is
- Frequently outdoors and refuses screen/protective clothing
- Sun sensitive
- Engages in self injurious behavior, such as picking, scratching etc
- Incontinent/requires preventive skin care

27.b Comments (include description of routine or PRN topical treatments and preventive skin care here):
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

Health Practices

28. Is individual receptive to participating in the development of goals and plans related to maintaining their health?
- No
- Yes

28.a Uses tobacco/nicotine products:
- Does not use tobacco/nicotine products
- Unknown status
- Smokes cigarettes or cigars
- Uses cig (electronic)
- Uses chewing tobacco
- Uses nicotine patch/gum
- Unsafe smoking - requires supervision or smoking apron to prevent accidental injury

28.b Uses street drugs/prescription drug abuse:
- Does not use
- Unknown Status
- Currently known to use
- Past history of street drug use/prescription

28.c Currently uses alcohol with a diagnosis of alcoholism?
- No
- Yes
- Unknown

28.d Has difficulty tolerating routine adult healthcare screening?
- No
- Yes – Describe: ______________________________________
- ______________________________________
- ______________________________________
28.e Requires pre-sedation/medical stabilization for medical visits or appointments  □ No  □ Yes

28.f Have health issues prevented desired level of participation in work or community inclusion activities?  □ No  □ Yes

28.g Accessing home health care for management of an acute or resolving medical condition?  □ No  □ Yes

28.h Receiving hospice services or palliative care?  □ No  □ Yes

28.i Comments: ____________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Other Comments
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

SIGNATURE ...................................... NAME ........................................ DATE .............................. TIME .............................. am/pm

Note: Required fields are marked with an asterisk (*)