### Physical Examination Procedure

Hands-on assessment and examination of body systems must be completed by the nurse, along with review of the following:

- [ ] Diagnosis
- [ ] Current medications and effectiveness
- [ ] Current diet and dietary restrictions
- [ ] Findings/recommendations of consultants (MD’s, PT’s, OT’s, etc.)

### Summary of General Health Status/Health History

- [ ] For Initial Assessments only: Summarize concisely the medical events/health history prior to admission to this facility.

- [ ] List the medical events occurring since the annual assessment. If none indicate, as such.

  **Major Illnesses** (type, frequency of each type, dates/duration, and general treatment): [ ] None

  **Hospitalizations** (number, duration, diagnoses, status of condition causing hospitalization): [ ] None

  **Major Illnesses** (type, frequency of each type, dates/duration, and general treatment): [ ] None

  **Injuries** (type, frequency of each type, dates/duration, and general treatment): [ ] None
Consultants (type, status of recommendations, and resolution of problem): [ ] None

New medical diagnoses (list with date of onset): [ ] None

Corrective devices (use and effectiveness): [ ] None

III. Review laboratory results, allergies and immunities
   A. Laboratory results
      1. Observation/Findings
         [ ] Initial laboratory test results were reviewed on: _____________________ (Date)
         [ ] Annual laboratory test results were reviewed on: _____________________ (Date)
         [ ] Laboratory test results were within normal limits and required no follow-up action.
         [ ] Laboratory test results were abnormal and follow-up action was required: (list abnormal results, follow-up action, and resolution):

      2. Intervention/Recommendations for IDT consideration [ ] No further action is needed

   B. Allergies
      1. Observation/Findings [ ] No Known Allergies
         [ ] When in contact with _____________________________ (environmental factors), the following reaction occurs: __________________
         [ ] When _____________________________ (medication) is taken, the following reaction occurs: __________________
[ ] When ____________________________ (food) is consumed, the following reaction occurs: ____________________________

The following precautions are in place: ________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

C. Immunity

1. Observation/Findings

Immunizations are current: [ ] PPD  [ ] Influenza  [ ] Pneumonia  [ ] Tetanus

Hepatitis surface antigen tested ___________________________(date), ___________________________(results)
Hepatitis core antigen tested ____________________________ (date), ____________________________ (results)
Hepatitis antibodies tested ______________________________(date), ____________________________ (results)

[ ] History of significant tuberculin skin test on ___________________________ (date)

Exhibits: [ ] weakness, [ ] anorexia (loss of appetite), [ ] weight loss, [ ] night sweats, [ ] low grade fever, [ ] productive cough, [ ] hemoptysis (blood in sputum). [ ] The above were addressed by the physician on ____________________________ (date).

HIV status: [ ] Unknown  [ ] Known

2. Intervention/Recommendations for IDT consideration  [ ] No further action is needed

[ ] ____________________________________________________________________________________________
[ ] ____________________________________________________________ (immunization) should be administered by ____________________________ (date)

IV. Body Systems Review And Physical Examination:

A. Integument

1. History & System Review

SKIN  [ ] No relevant history

[ ] History of skin problems/disorders: _____________________________________________________________

[ ] Chronic skin problem: ________________________________________________________________

[ ] presently active  [ ] inactive  (description & location)

History of:
[ ] trauma to skin: ______________________________________________________________

[ ] wound healing problems: ______________________________________________________________

[ ] hair loss  [ ] head lice  [ ] scabies

Skin Integrity Assessment yielded score indicating: [ ] high risk  [ ] moderate risk  [ ] low/no risk of developing pressure sores

Comments: ______________________________________________________________________________

_____________________________________________________________________________________

______________________________

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Individual’s Name: ________________________________
Date of Birth: ____________________ Sex: __________
DHS ID#: ____________________________ Date: __________
Unit/Subunit: ________________________ Date: __________
2. Physical Exam findings

**SKIN**
- clear, healthy skin
- clear, healthy scalp
- no problems or deviations assessed
- lesions
- rashes
- bruises
- wound
- drainage
- itching
- skin color variation
- cyanosis
- pallor
- jaundice
- erythema
- dry, rough texture
- scaling/xerosis
- poor tugor
- edema
- unusual hair distribution
- hair loss
- reduced hair on extremities
- hirsutism
- hair characteristics
- normal
- oily
- dry
- coarse
- infestation/lice

Comments: ____________________________________________________________

**STOMA**
- Not Applicable
- clean, dry
- redness
- chronic redness
- drainage
- chronic drainage
- prolapse

Comments: ____________________________________________________________

**FINGERNAILS & TOENAILS**
- color, shape, cleanliness good
- no problems or deviations assessed
- irregularities in surface
- inflammation around nails
- fungal problem

Comments: ____________________________________________________________
3. **Interventions/Recommendations for IDT Consideration**

**SKIN**

- [ ] Not Applicable
- [ ] Current nursing interventions to continue

Nursing interventions to be initiated or change:

- [ ] Special bathing procedure:
- [ ] Special soap or shampoo: __________________________ Lotions, emollient: __________________________
- [ ] Fluid intake: __________________________ [ ] Sunscreen when outside during summer months
- [ ] Dietary modifications: __________________________
- [ ] Clothing, linen precautions: __________________________
- [ ] Incontinent brief: (size) __________________________ schedule/when: __________________________
- [ ] Special perineal care: __________________________
- [ ] Positioning/repositioning needs: __________________________
- [ ] Rest periods: __________________________

Comments: ________________________________________________________________________________________________

**STOMA**

- [ ] Not Applicable
- [ ] Current nursing interventions to continue

Nursing interventions to be initiated or change:

- [ ] Minimum inspection schedule (at least daily) __________________________
- [ ] Cleaning: __________________________ (product & frequency)
- [ ] Dressing: __________________________ (type & frequency)

Comments: ________________________________________________________________________________________________

**FINGERNAILS & TOENAILS**

- [ ] Not Applicable
- [ ] Current nursing interventions to continue
- [ ] Routine nail care

Nursing interventions to be initiated or change:

- [ ] Special nail care __________________________

Comments: ________________________________________________________________________________________________
B. Head and Neck

1. History & System Review

   HEAD & NECK  [  ] No relevant history

   History of:  [  ] head trauma  [  ] macrocephaly  [  ] microcephaly  [  ] hydrocephalus  [  ] shunt
   [  ] head banging  [  ] slapping head/face  [  ] hypothyroidism  [  ] frequent colds
   [  ] frequent infections  [  ] neck injuries  [  ] displaced trachea

   [  ] Pain: ___________________________ (location & description)

   Comments: ________________________________________________________________

   NOSE & SINUSES  [  ] No relevant history

   History of:  [  ] nosebleeds  [  ] sinus infections  [  ] Allergies  [  ] Snoring  [  ] difficulty breathing
   [  ] discharge  [  ] drip  [  ] uses inhalants  [  ] headaches  [  ] recent trauma  [  ] surgery
   [  ] places foreign objects in nose

   Comments: ________________________________________________________________

   MOUTH & PHARYNX  [  ] No relevant history

   History of:  [  ] dental problems  [  ] impaired swallowing  [  ] recent appetite or weight change
   [  ] chewing problems  [  ] mouth pain  [  ] mouth lesions  [  ] self-injurious behavior (biting)
   [  ] risk for tongue injury (seizures, biting)  [  ] places foreign objects in mouth & pharynx  [  ] cleft lip or palate

   Comments: ________________________________________________________________

2. Physical Exam findings

   HEAD & NECK  [  ] No problems or deviations assessed

   head motion: ______________________________________________________________

   [  ] asymmetric head position: _____________________________________________

   [  ] shrugs shoulders  [  ] unable to support head midline & erect  [  ] dull, puffy, yellow skin

   [  ] periorbital edema  [  ] lymph node enlargement  [  ] thyroid enlargement  [  ] tracheal displacement

   Comments: ________________________________________________________________

   NOSE & SINUSES  [  ] No problems or deviations assessed

   [  ] nasal drainage  [  ] inflamed  [  ] tender  [  ] polyps/lesions  [  ] edema

   [  ] altered nasal mucosa: __________________________________________________

   [  ] absence of frontal sinus glow  [  ] right nostril occluded  [  ] left nostril occluded

   Comments: ________________________________________________________________
MOUTH & PHARYNX  [ ] No problems or deviations assessed

[ ] altered oral mucous membrane: _______________________________ (describe)

[ ] inflammation: _______________________________ (describe)

[ ] hoarseness [ ] bruxism (grinds teeth) [ ] loose teeth [ ] decay [ ] halitosis [ ] excessive salivation

[ ] lips dry, cracked [ ] lip fissures [ ] lip bleeding [ ] gums inflamed [ ] gums bleed [ ] gum retraction

[ ] thick tongue [ ] tongue dry, cracked [ ] tongue fissures [ ] tongue bleeds

Inspect the following: [ ] inner oral mucosa [ ] buccal mucosa [ ] floor of mouth [ ] tongue

[ ] hard palate [ ] soft palate

Deviations: __________________________________________________________ (describe)

_____________________________________________________________________

[ ] lesions, vesicles: __________________________________________________ (describe)

[ ] gag reflex absent [ ] gag reflex hyperactive [ ] poor denture fit or not using [ ] chewing problem [ ] missing teeth

Comments: __________________________________________________________

_____________________________________________________________________

3. **Interventions/Recommendations for IDT Consideration**

**HEAD & NECK**  [ ] Not Applicable  [ ] Current nursing interventions to continue

Nursing interventions to be initiated or change: ______________________________

Comments: __________________________________________________________

_____________________________________________________________________

**NOSE & SINUSES**  [ ] Not Applicable  [ ] Current nursing interventions to continue

Nursing interventions to be initiated or change: ______________________________

Comments: __________________________________________________________

_____________________________________________________________________

**MOUTH & PHARYNX**  [ ] Not Applicable  [ ] Current nursing interventions to continue

Nursing interventions to be initiated or change: ______________________________

Comments: __________________________________________________________
C. Eyes and Ears

1. History & System Review

EYES
[ ] No relevant history
[ ] medications that place individual at risk for glaucoma or cataracts
[ ] keratoconus
[ ] retinal detachment
[ ] corrective lenses
[ ] contacts
[ ] legally blind
[ ] total blindness (no vision)
History of:
[ ] eye infection
[ ] inflammation
[ ] disease
[ ] drainage
[ ] eye surgery
[ ] trauma
[ ] diabetes
[ ] hypertension
[ ] eye pain
[ ] cataracts
[ ] glaucoma
[ ] glaucoma suspect
[ ] using drops
[ ] redness, irritation
[ ] itching/rubbing eyes
[ ] places foreign objects in eyes

Last eye exam (optometrist/ophthalmologist) _________________________ (date)

Comments: ________________________________________________________________________________________________

EARS
[ ] No relevant history

History of:
[ ] infections
[ ] drainage
[ ] redness
[ ] pain
[ ] tinnitus
[ ] vertigo
[ ] disorder(s)
[ ] chronic otitis media
[ ] tubes
[ ] itching or pulling ears
[ ] excessive cerumen
[ ] foreign objects in ears
[ ] hearing problems
[ ] hearing aide
[ ] ototoxic medications

Last hearing exam (audiologist) _________________________ (date)

Comments: ________________________________________________________________________________________________

2. Physical Exam findings

EYES
Visual acuity: ____________________________ (method & results)
visual fields/peripheral vision present:
[ ] right
[ ] left
eye tracking present:
[ ] up
[ ] down
[ ] right
[ ] left
[ ] corneal light reflex aligned
[ ] light reflex misaligned
[ ] nystagmus
inspected the external eye structures:
[ ] eyebrows
[ ] orbital area
[ ] eyelids
[ ] lacrimal ducts
[ ] conjunctiva
[ ] sclera
[ ] cornea

abnormalities: ______________________________________________________________________________________________
Blink reflex:
Right:
[ ] present
[ ] absent
Left:
[ ] present
[ ] absent

Pupil & iris direct light response:
[ ] present
[ ] absent

Pupil & iris consensual light response:
[ ] present
[ ] absent

Ophthalmoscopic exam:
[ ] red reflex obtained
[ ] red reflex not obtained

Unable to do ophthalmoscope exam due to: ______________________________________________________________________

Comments: ________________________________________________________________________________________________

EARS
Inspected the following external ear structures:
[ ] auricle
[ ] lobule
[ ] tragus
[ ] mastoid
External ear structure abnormalities:
[ ] swelling
[ ] nodules
[ ] tenderness
[ ] discharge

Other abnormalities: __________________________________________________________________________________________

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Otoscopic exam: [ ] cone of light visualized [ ] cone of light not visualized
[ ] tympanic membrane inspected [ ] excessive cerumen
[ ] Unable to examine

[ ] Simple hearing acuity test: ____________________________________________________ (method & response)

Comments: ________________________________________________________________________________________________

3. **Interventions/Recommendations for IDT Consideration**

**EYES & EARS**  [ ] Not Applicable  [ ] Current nursing interventions to continue

Nursing interventions to be initiated or changed:

[ ] Special eye care: ___________________________________________________________ (describe)

[ ] Corrective lens(es)

[ ] Special ear care: ___________________________________________________________ (describe)

[ ] Hearing aid

[ ] Routine ear lavage: ________________________________________________________ (describe)

[ ] Ear plugs in bath

[ ] Consultation: ________________________________________________________________________________________________

Comments: ________________________________________________________________________________________________

D. **Cardiopulmonary**

1. **History & System Review**

**HEART & VASCULAR**  [ ] No relevant history

History of Congenital Heart Disease: [ ] endocardial cushion defect [ ] septal defect(s) [ ] mitral prolapse
[ ] Tetrology of Fallot [ ] mitral regurgitation [ ] murmurs [ ] extra heart sounds (clicks, rubs)
[ ] pulmonic stenosis [ ] coarctation of the aorta (malformed narrowing)

History of Cardiovascular Disease: [ ] congestive heart failure [ ] endocarditis [ ] myocardial infarction

[ ] pre-medicate with antibiotics for dental or invasive procedures

[ ] Pain: (Location) _____________________________________________________________ (include precipitating and relieving factors)

[ ] known abnormalities regarding B/P and pulses: ________________________________________________________________________________________________

**History of**: [ ] smoking [ ] excessive caffeine [ ] diabetes [ ] hypertension [ ] swelling [ ] peripheral vascular disease [ ] phlebitis [ ] varicose veins [ ] leg cramps [ ] cyanosis [ ] dependent edema

[ ] pacemaker _____________________________________________________________ (specify)

[ ] nausea [ ] dyspnea [ ] fatigue [ ] palpitations [ ] tingling or numbness

__________________________  ____________________________  __________________________
Individual’s Name: Date of Birth:  Sex:  DHS ID:
__________________________  ____________________________  __________________________
Unit/Subunit: Date:  __________
THORAX & LUNGS  [ ] No relevant history

History of:  [ ] respiratory disease  [ ] reoccurring pneumonia  [ ] recurrent aspiration syndrome  [ ] COPD
[ ] asthma  [ ] Past positive TB  [ ] smoking  [ ] allergies  [ ] risk factors for aspiration present
[ ] esophageal motility disorders  [ ] hiatal hernia with reflux  [ ] achalasia (failure of sphincter to relax)
[ ] gastroesophageal reflux  [ ] chronic constipation & increased intra-abdominal pressure
[ ] delayed stomach emptying  [ ] high frequency vomiting  [ ] regurgitation
[ ] nasal feeding tube  [ ] impaired swallow reflex  [ ] absent or hyperactive gag reflex
[ ] reduced level consciousness  [ ] infectious saliva from poor oral hygiene  [ ] seizure disorders
[ ] spinal deformities or orthopedic corsets that increase intra-abdominal pressure
[ ] dependency for feeding & positioning  [ ] impaired cough reflex  [ ] aerophagia  [ ] pica
[ ] ingestion of hydrocarbon derivatives (glue, acetone)  [ ] hoarseness  [ ] wheezing

[ ] cough: ______________________________________________________ (describe)
[ ] expectorate: ___________________________________________________ (character, quantity & color)
[ ] Pain: ________________________________________________________ (location, precipitating & relieving factors)
[ ] ventilation problem: ____________________________________________ (describe)

[ ] Tracheostomy: __________________________________________________ (tube type & size) __________________ (Procedure Date)

Reason for: ____________________________________________________________

Current Care: __________________________________________________________

[ ] TB test: ________________________________________________________ (date & result)

Comments: ________________________________________________________________________________________________

2. Physical Exam findings

HEART & VASCULAR  [ ] No problems or deviations assessed

Auscultated heart sounds:  [ ] S-1 at 5th intercostal space on left  [ ] S-2 at 2nd intercostal space left or right side

apical pulse: ___________________ (rate & rhythm) Jugular venous distention:  [ ] present  [ ] absent
Capillary refill:  [ ] > 1 second  [ ] < 2 seconds
[ ] PMI palpable – 5th intercostal space medial to left midclavicular line  [ ] PMI not palpable

[ ] edema: ____________________________________________________________ (describe)

Blood Pressure
right arm: ___________________ (sitting) ___________________ (standing) ___________________ (lying)
left arm: ___________________ (sitting) ___________________ (standing) ___________________ (lying)

The following pulses could be palpated bilaterally:  [ ] radial  [ ] ulnar  [ ] brachial  [ ] femoral
[ ] popliteal  [ ] dorsal pedis  [ ] posterior tibial

List pulse deviations: ____________________________________________________________
Comments: ________________________________________________________________________________________________

**THORAX & LUNGS**  [  ] No problems or deviations assessed

Inspected:  [  ] posterior thorax  [  ] lateral thorax  [  ] anterior thorax

List thorax deviations: ________________________________________________________________________________________________

[  ] scoliosis  [  ] lordosis  [  ] barrel chest  [  ] intercostal bulging

Auscultated breath sounds:  [  ] vesicular sounds at periphery  [  ] bronchovesicular sounds between scapulae or 1st – 2nd intercostal space lateral to sternum  [  ] bronchial sounds over trachea

Diminished sounds: __________________________________________________________________________________

[  ] wheezes  [  ] crackles  [  ] rhonchi (Location(s))______________________________

[  ] clear with cough

List breath sound deviations: __________________________________________________________________________________

Respiratory distress:  [  ] nasal flaring  [  ] use of accessory muscles  [  ] SOB  [  ] intercostal retraction

Respiratory Rate: _________________________ Pulse oximetry %: _________________________

[  ] apnea monitor

Comments: ________________________________________________________________________________________________

3. **Interventions/Recommendations for IDT Consideration**

**CARDIOPULMONARY**  [  ] Not Applicable  [  ] Current nursing interventions to continue

Nursing interventions to be initiated or changed: _________________________________________________________________________

________________________________________________________________________________________________________

[  ] Cardiology consultation to evaluate: ___________________________________________________________________________

[  ] Pulmonology/Respiratory consultation to evaluate: __________________________________________________________________

[  ] Tracheostomy weaning protocol: ________________________________________________________________________________

Comments: ________________________________________________________________________________________________
E. Gastrointestinal

1. History & System Review

**ABDOMEN**

- [ ] No relevant history

**History of:**

- [ ] constipation
- [ ] diarrhea
- [ ] incontinence
- [ ] foul odor
- [ ] flatulence
- [ ] abnormal stool color
- [ ] frequent belching
- [ ] distention
- [ ] GI/hepatobiliary infection
- [ ] parasites
- [ ] infectious hepatitis
- [ ] chronic liver disease
- [ ] pancreatitis
- [ ] nausea
- [ ] vomiting
- [ ] pain

Surgical history: ________________________________

Disorders of abdominal organs:

- [ ] stomach
- [ ] small intestine
- [ ] large intestine
- [ ] appendix
- [ ] pancreas
- [ ] gallbladder
- [ ] spleen

Ostomy presence:

- [ ] gastrostomy
- [ ] jejunostomy
- [ ] large intestine ostomy
- [ ] appliance: ____________________________
- [ ] self-care of ostomy
- [ ] dependent care of ostomy

Bowel movement:

- [ ] Normal
- [ ] small
- [ ] medium
- [ ] large
- [ ] soft
- [ ] formed
- [ ] hard

Current Bowel Program: (Bowel movement = BM)

- [ ] BM every ________ days without special aide

- [ ] BM every ________ days with ________________________________ (dietary measures)

- [ ] BM every ________ days with at least ______________ oz fluids/24 hours

- [ ] BM every ________ days with ____________________________ (oral medication(s))

- [ ] BM every ________ days with __________________________ (suppository/enema regime)

- [ ] Monitoring of BMs

- [ ] Bowel training program: ______________________________________________________________

Comments: ____________________________________________________________________________________

**NUTRITIONAL/METABOLIC PATTERN**

- [ ] No relevant history

**Nutritional Status:**

- [ ] good appetite
- [ ] poor appetite or loss of appetite

Weight fluctuations:

- [ ] None significant
- [ ] gained
- [ ] lost in last __________________________ (month(s) or year)

**Eating Skills:**

- [ ] too slow
- [ ] too fast
- [ ] excessive spillage
- [ ] requires special utensils
- [ ] needs to be positioned

**Swallowing:**

- [ ] difficulty
- [ ] delayed
- [ ] pockets food
- [ ] silent aspiration
- [ ] no thin liquids

- [ ] Special diet
- [ ] special feeding techniques: ____________________________________________________________ (describe)

**Enteral Feedings:**

Reason:

- [ ] dysphagia
- [ ] surgery
- [ ] hypermetabolic status (burns, trauma, sepsis, cancer)
- [ ] GI disease
- [ ] Other: ____________________________________________________________

Tube Type:

- [ ] nasogastric
- [ ] gastrostomy
- [ ] jejunostomy

Tube size: __________________________

Type of infusion:

- [ ] pump
- [ ] bolus

Type of procedure: ________________________________________________________________
2. **Physical Exam findings**

**ABDOMEN**
- [ ] No problems or deviations assessed
- **Bowel Sounds**
  - [ ] Present in all quadrants
  - [ ] absent: ____________________________
  - [ ] hypoactive
  - [ ] hyperactive
  - [ ] tympanic
- **Abdomen**
  - [ ] flat
  - [ ] distended
  - [ ] soft
  - [ ] firm
  - [ ] rounded
  - [ ] obese
  - [ ] asymmetry
  - [ ] pain
  - [ ] rebound tenderness
- [ ] **umbilical hernia:** ______________________________________________________________________ (describe)
- [ ] gastrostomy
- [ ] jejunostomy
- [ ] large intestine transverse ostomy
- [ ] large intestine sigmoid ostomy
- [ ] mass: ______________________________________________________________________________________ (describe)

**Skin:** _________________________________________ (texture) ____________________ (color)

**Comments:** ________________________________________________________________________________________________

---

**NUTRITIONAL/METABOLIC PATTERN(S)**
- [ ] No problems or deviations assessed
- **Height:** ________ **Weight:** ____________
  - [ ] within Ideal Body Weight (IBW)
  - [ ] less than IBW
  - [ ] more than IBW

**Comments:** ________________________________________________________________________________________________

---

3. **Interventions/Recommendations for IDT Consideration**

**GASTROINTESTINAL**
- [ ] Not Applicable
- [ ] Current nursing interventions for bowel program to continue

**Nursing interventions to be initiated or changed:** ___________________________________________________________________
__________________________________________________________________________________________________________

- [ ] Current nursing intervention for enteral feeding program to continue

**Nursing interventions for enteral feeding program to be initiated or changed:** ___________________________________________________________________
__________________________________________________________________________________________________________

- [ ] **positioning:** _________________________________________________________________________________________
- [ ] check tube placement
- [ ] Tube replacement frequency: ____________ [ ] Residual check frequency: ____________
- [ ] monitor emesis
- [ ] monitor stools
- [ ] monitor lab values: __________________________________________________________________________________________
- [ ] Protocol for holding feeding: _______________________________________________________________________________

- [ ] Gastroenterology consultation to evaluate: __________________________________________________________________
- [ ] Videofluoroscopy
- [ ] Esophagogastroduodenoscopy (EGD)
- [ ] Nutritional evaluation

- [ ] Weighting schedule change: ___________________________________________________________________________________

- [ ] Dental consultation to evaluate: _______________________________________________________________________________
[ ] Oral Motor assessment to evaluate: ____________________________________________________________
[ ] Behavioral assessment to evaluate: ___________________________________________________________
[ ] Occupational Therapy assessment to evaluate: __________________________________________________

Comments: __________________________________________________________________________________

F. Genitourinary (Gynecological & Breasts)

1. History & System Review

GENITOURINARY [ ] No relevant history

Bladder: Frequency: [ ] nocturia [ ] urgency [ ] dysuria [ ] pain/burning [ ] oliguria [ ] hematuria [ ] urine clear [ ] urine cloudy [ ] urinary retention [ ] foul odor to urine.

[ ] indwelling catheter [ ] external catheter [ ] Intermittent catheterization [ ] History of chronic urinary infection

[ ] incontinence ______(total) ______(daytime) ______(nighttime) ______(occasional)
[ ] difficult delayed voiding

Current bladder program: [ ] Dietary measures: __________________________________________________________
[ ] medication(s): __________________________________________________________ (list)
[ ] bladder training: __________________________________________________________ (list)
[ ] intermittent catheterization: ________________________________________________ (schedule)
[ ] monitoring of urinary frequency [ ] fluid intake/output

[ ] sexually active [ ] with partner(s) [ ] by self [ ] unknown [ ] last PSA: ____________________ (date & result)

Comments: __________________________________________________________________________________

GYNECOLOGICAL & BREASTS [ ] No relevant history

[ ] regular menses [ ] irregular menses [ ] primary amenorrhea [ ] secondary amenorrhea [ ] menopausal
[ ] post hysterectomy [ ] heavy flow [ ] dysmenorrheal

Surgical History: __________________________________________________________________________________

[ ] no significant findings on monthly breast examination

[ ] significant findings on monthly breast examination on _________________ (date) with following action: ____________________

[ ] independent breast self-exam [ ] needs instructions [ ] unable to complete

last Pap test done: ________________ (date) __________________________________________ (result with date)

Comments: __________________________________________________________________________________

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2. **Physical Exam findings**

**GENITOURINARY & GYNECOLOGIC**

- No problems or deviations assessed
- External genitalia inspected:
  - excoriations
  - rash
  - lesions
  - vesicles
  - inflammation
  - bright red color
  - swelling
  - bulging
  - discharge
  - inguinal hernia
  - tight scrotal skin
  - large scrotum
  - phimosis
  - balanitis
  - displace meatus
- Testicular self exam:
  - independent
  - needs instructions to complete
  - unable to complete

Comments: ________________________________________________________________________________________________

**BREASTS**

- No problems or deviations assessed
- Deviations assessed in:
  - size
  - symmetry
  - contour
  - shape
  - skin color
  - texture
  - venous pattern
- Nipple deviations:
  - retraction
  - discharge
  - bleeding
  - nodules
  - edema
  - ulcerations

Comments: ________________________________________________________________________________________________

3. **Interventions/Recommendations for IDT Consideration**

**GENITOURINARY & GYNECOLOGIC**

- Not Applicable
- Current nursing interventions for bladder program to continue
- Nursing interventions for bladder program to be initiated or changed: _______________________________________________

- Current nursing interventions for gynecological care to continue
- Nursing interventions for gynecological care to be initiated or changed:
  - Birth Control
  - Hormone replacement therapy
  - Analgesic therapy
  - Pad count
  - Hemoglobin and hematocrit every __________________ months
  - Pelvic examination with PAP smear
  - CT Scan
  - Baseline Mammography
  - PSA
  - Rectal examination
  - Urology consultation to evaluate: ____________________________________________________________________________
  - Gynecological consultation to evaluate: ______________________________________________________________________

Comments: ________________________________________________________________________________________________

---

G. **Musculoskeletal**

1. **History & System Review**

- No relevant history.
- History of:
  - arthritis
  - inflammatory disease
  - pain/cramps
  - swelling
  - fracture: ___________________________________________________________________________ (describe)
  - ambulatory
  - nonambulatory
  - mobile using: ____________________________________________
  - immobile

**Positioning:**

- adequately repositions/alters position independently
- requires verbal cues to reposition/alter position during day activities
- requires total assistance to reposition/alter position for day activities but adequately repositions/alters position when lying down
- requires total assistance to reposition/alter position at all times
- expresses need to be repositioned/have position altered
Current Positioning Program

[ ] Reminder to reposition/alter position every _________ hours while awake
[ ] Total assistance to reposition/alter position every _________ hours during daytime activities
[ ] Total assistance to positioning/alter position every _________ hours

Positioning devices include:
[ ] Wheelchair:

[ ] Alternative wheel chair usage:

[ ] Pillows/wedges:

[ ] Mat:

[ ] Adjustable bed:

[ ] Bedrails:

[ ] Bolster:

[ ] Other (scooter, walker, prone, stander):

[ ] Orthotic devices:

Comments: __________________________________________

2. Physical Exam findings

[ ] No problems or deviations assessed
[ ] gait abnormalities: ______________________________________
[ ] posture abnormalities:

[ ] impaired weight bearing stance: __________________________
[ ] bilateral symmetry:

[ ] asymmetry:

[ ] bilateral alignment:

[ ] misalignment:

[ ] decreased ROM:

[ ] joint swelling [ ] stiffness [ ] tenderness

[ ] Heat:

[ ] increased muscle tone (hypertonicity):

[ ] hypotonicity:

Comments: __________________________________________________________________________
3. **Interventions/Recommendations for IDT Consideration**
   - [ ] Not Applicable
   - [ ] Current nursing interventions for positioning to continue
   - [ ] Nursing interventions for positioning to be initiated or changed: ____________________________________________________

   - [ ] Nursing interventions for mobility to be initiated or changed: ____________________________________________________

   - [ ] Orthopedic consultation to evaluate: ___________________________________________________________

   Comments: ______________________________________________________________________________________________

---

H. **Neurologic System**

1. **History & System Review**

   **MENTAL & EMOTIONAL STATUS**
   - [ ] alert  [ ] aware of environment  [ ] non-verbal  [ ] impaired level of consciousness
   - [ ] able to communicate  [ ] limited verbalization  [ ] vocalized sounds only

   - [ ] Communication device: ____________________________________________________________
   - [ ] intellectual impairment  [ ] memory impairment  [ ] general knowledge deficit  [ ] abstract reasoning impaired
   - [ ] impaired association ability  [ ] impaired judgment  [ ] sleeps well at night  [ ] difficulty falling asleep
   - [ ] difficulty staying asleep  [ ] difficulty with early awakening
   - [ ] naps during day due to: [ ] age  [ ] health status  [ ] medications

   - [ ] sleep aids used: ________________________________________________________________
   - [ ] sleep safety devices used: [ ] bedrails  [ ] pillow(s)  [ ] mat beside bed
   - [ ] other: _____________________________________________________________________________

   - [ ] pillow restriction due to: __________________________________________________________

   Comments: ______________________________________________________________________________________________

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**BEHAVIOR**

- [ ] No maladaptive behaviors
- Maladaptive Behaviors:
  - [ ] self injurious behavior  [ ] aggression to others  [ ] PICA behavior  [ ] mood swings

  - [ ] receives: ________________________________ (medication) for behavior(s)

- [ ] a behavior program is in place  [ ] an exception to behavior medication reduction is in place

Comments: ______________________________________________________________________________________________
SEIZURE DISORDERS & EPILEPSY

[ ] No relevant history
[ ] History of seizure disorder (see Seizure Outcome Assessment form)

Comments: ____________________________________________________________

TARDIVE DYSKINESIA & MOVEMENT DISORDERS

History of:
[ ] movement disorder
[ ] Huntington’s disease
[ ] Parkinson’s disease
[ ] benign essential tremor
[ ] resting tremor
[ ] bradykinesia
[ ] clonus
[ ] Other: _____________________________________________________________ (specify)

[ ] Receiving antipsychotic/amoxapine/metoclopramide: ______________________

Baseline TD assessment was completed on ______________________ (date) with the following results: ______________________

TD assessment completed during the past year:
_________________________ (date) ______________________ (Result)
_________________________ (date) ______________________ (Result)

Comments: ____________________________________________________________

OTHER NEUROLOGIC CONDITIONS

[ ] No other neurologic problems noted

Description (including signs & symptoms of neurologic problem not noted above): ____________________________

CT scan date: ______________________ Results: ____________________________________________________________

MRI date: ______________________ Results: __________________________________________________________________

Baseline EEG date: ________________ Results: ________________________________________________________________

Latest EEG date: ________________ Results: ________________________________________________________________

Neurologic consultation during past year date: ________________ Significant findings: ________________________________

Neurologist recommendations: __________________________________________________________

Comments: ____________________________________________________________
2. Physical Exam findings

MENTAL & EMOTIONAL STATUS

[ ] No problems or deviations assessed

Glasgow coma scale score: ______________________

Communication device: ________________________

[ ] intellectual impairment unchanged
[ ] memory impairment unchanged
[ ] general knowledge deficit unchanged

[ ] abstract reasoning unchanged
[ ] impaired association ability unchanged
[ ] impaired judgment unchanged

[ ] changes in mental & emotional status (describe): _____________________________________________________

Comments: ____________________________________________________________________________________________

CRANIAL NERVE (CN) FUNCTION

CN I – olfactory [ ] intact [ ] impaired [ ] unknown

CN's II-III-IV-V – optic, oculomotor, trochlear, abducens (see eye exam)

CN VI – trigeminal (facial sensory & jaw motor) [ ] intact [ ] impaired

CN VII - Facial (symmetry in face expressions & taste) [ ] intact [ ] impaired

CN VIII – Acoustic (see hearing exam)

CN IX – Glossopharyngeal (taste at back of tongue) [ ] intact [ ] impaired

CN X - Vagus (palate movement, “ah” and vocal motor) [ ] intact [ ] impaired

CN XI – Spinal Accessory (head motion & shrug) [ ] intact [ ] impaired

CN XII – Hypoglossal (tongue position & motor) [ ] intact [ ] impaired

SENSORY FUNCTION

Touch [ ] intact [ ] impaired: ____________________________ (describe)

Pain [ ] intact [ ] impaired: ____________________________________________________________________________

MOTOR FUNCTION

[ ] impaired coordination [ ] fine motor skills impaired

[ ] balance maintained while standing with eyes closed [ ] loss of balance immediate

REFLEXES

patellar reflex: [ ] 0: no response [ ] 1+ low (normal with slight contraction
[ ] 2+ normal, visible muscle twitch and extension of lower leg
[ ] 3+ brisker than normal
[ ] 4+ hyperactive, very brisk

3. Interventions/Recommendations for IDT Consideration

MENTAL & EMOTIONAL STATUS [ ] Not Applicable

[ ] Current interventions for alertness to continue [ ] Current nursing interventions for behavior to continue

[ ] Nursing interventions to be initiated or changed for alertness: _____________________________________________

[ ] sleep aids [ ] evaluation of schedule [ ] evaluation of activities

[ ] respite/nap [ ] early bedtime: ________________________________
[ ] evaluation of medications  use of sleep safety devices: [ ] bedrails  [ ] pillow  [ ] mat beside bed  [ ] other

[ ] Nursing interventions for behavior to be initiated or changed: ________________________________________________

[ ] Other: ______________________________________________________________________________________________

Comments: ______________________________________________________________________________________________

SEIZURE DISORDERS & EPILEPSY  [ ] Not Applicable

[ ] Current interventions for alertness to continue  [ ] Current nursing interventions for behavior to continue

[ ] Nursing interventions to be initiated or changed: ______________________________________________________________

[ ] Neurologic consultation to evaluate:

[ ] discuss phenobarbital replacement  [ ] discuss monotherapy
[ ] discuss anticonvulsant reduction due to no seizures for past 5 years  [ ] repeat EEG as needed.

[ ] Other: ______________________________________________________________________________________________

Comments: ______________________________________________________________________________________________

V. Individual’s Preference/Choice

[ ] Individual did not specify services or health outcomes to be obtained as a result as assessment.
[ ] Individual specified he/she desired the following health outcomes and services.

VI. Medical Care Plan is [ ] not recommended  [ ] recommended due to: ________________________________________________

Completed by: ________________________________________________________________  [ ] RN ___________________ (Date)

R-04-01-11