Section 12

Sample Nursing Assessment Form

Training Program for Authorized Non-licensed Direct Care Staff
I. 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 diet and dietary restrictions
[ ] Current medications and effectiveness  [ ] Findings/recommendations of consultants (MD's, PT's, OT's, etc.)

II. 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

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Individual’s Name: _______________________________  Date of Birth: ___________________  Sex: ________

DHS ID#: ____________________________________  Unit/Subunit: ____________________  Date: ______________
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 review on: _____________________ (Date)
      [ ] Annual laboratory test results were review 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):

      [ ] 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: ________________________________
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**

- [ ] 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: ____________________________________________________________

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Individual's Name: _________________________________
Date of Birth: ___________________ Sex: __________
DHS ID#: _________________________________________
Unit/Subunit: ____________________  Date: ____________
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: ________________________________ (describe)

   [ ] asymmetric head position: ________________________________ (describe)

   [ ] 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: ________________________________ (describe)

   [ ] 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: _________________________________________________________________________________________________ (specify/describe)

   **Blink reflex:**
   - Right: [ ] present [ ] absent
   - Left: [ ] present [ ] absent

   **Pupil & iris direct light response:**
   - [ ] present [ ] absent
   - Left: [ ] present [ ] absent

   **Pupil & iris consensual light response:**
   - [ ] present [ ] absent
   - Left: [ ] 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: ______________________________________________________________ (specify)
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 [ ] coartation 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#: ____________________________ Date: __________

Unit/Subunit: ____________________________
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 reflex  [   ] 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  [   ] dorsalis pedis  [   ] posterior tibial

List pulse deviations: ________________________________________________________________

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Individual’s Name: ____________________________________________
Date of Birth: ________________________ Sex: ________
DHS ID#: ____________________________________________ Date: ________________________
Unit/Subunit: ____________________________________________ Date: ________________________
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: _________________________________________________________________ (describe)

[ ] 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 _______________ oz fluids/24 hours (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 ________________ pounds [ ] gained [ ] lost in last ________________ month(s) or year
   [ ] recurrent emesis [ ] rumination

   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: ________________________________

   **Abdomen**:
   - [ ] hypoactive
   - [ ] hyperactive
   - [ ] tympanic
   - [ ] 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**: ________________________________________________________________________________________________

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

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

   **Nursing interventions to be initiated or changed**: ____________________________________________________________

   **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
   [ ] Esophagogastrduodenoscopy (EGD)
   [ ] Nutritional evaluation

   [ ] Weighting schedule change: ____________________________________________

   [ ] Dental consultation to evaluate: ____________________________________________

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**N-02-01-11**

**Individual’s Name:** ________________________________

**Date of Birth:** ________________________________ **Sex:** _______

**DHS ID#:** ____________________________________________

**Unit/Subunit:** ________________________________ **Date:** ____________
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: ____________________________________________________________ (list)
- [ ] medication(s): _______________________________________________________________(list)
- [ ] bladder training: ____________________________________________________________ (schedule)
- [ ] intermittent catheterization: ________________________________________________ (schedule)
- [ ] monitoring of urinary frequency [ ] fluid intake/output

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

**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: ____________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

N-02-01-11
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: _________________________________

Individual’s Name: _________________________________
Date of Birth: _________________________________ Sex: ________
DHS ID#: _________________________________ Date: ____________
Unit/Subunit: _________________________________
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: __________________________________________________________________________________

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: __________________________________________________________________________________

N-02-01-11
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
[ ] resting tremor  [ ] parkinson's
[ ] benign essential tremor  [ ] bradykinesia
[ ] 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)

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**

[ ] No problems or deviations assessed

**MENTAL & EMOTIONAL STATUS**

[ ] alert  [ ] aware of environment  [ ] impaired consciousness  [ ] Glasgow coma scale score: __________________

[ ] changed level of consciousness  [ ] unchanged level of consciousness

[ ] able to communicate  [ ] vocalizes sounds  [ ] limited verbalization  [ ] non-verbal

[ ] change in communication pattern  [ ] unchanged communication

---

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): ________________________________________________________________

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**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: ________________________________ (describe)

**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