Section 4

Sample Nursing Assessment Form

Training Program
for
Authorized Non-licensed Direct Care Staff
NURSING ASSESSMENT
Sample

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>D.O.B.</th>
<th>GENDER</th>
<th>I.D. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Assessment: [ ] Initial [ ] Annual [ ] Other:</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

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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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):

   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#: ____________________________
Unit/Subunit: ____________________________ Date: __________
STOMA  [ ] Not Applicable  
  [ ] trachestomy  [ ] colostomy  [ ] ileostomy  [ ] gastrostomy  [ ] jejunostomy

Comments: ________________________________________________________________________________________________
______________________________________________________________________________________________

FINGERNAILS & TOENAILS  [ ] No relevant history

[ ] history of trauma: ________________________________________________________________________________________________
[ ] changes in appearance/growth: ________________________________________________________________________________________________
[ ] at risk factors (diabetic): ________________________________________________________________________________________________
[ ] chronic fungus problem: ________________________________________________________________________________________________
  (description & locations)
[ ] presently active  [ ] inactive

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  [ ] 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: ________________________________________________________________________________________________
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:
  - [ ] Fluid intake:
  - [ ] Dietary modifications:
  - [ ] Clothing, linen precautions:
  - [ ] Incontinent brief: (size) schedule/when:
  - [ ] Special perineal care:
  - [ ] Positioning/repositioning needs:
  - [ ] Rest periods:

**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)

**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: ________________________________________________________________________________________________

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**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: ________________________________________________________________________________________________

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**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: ________________________________________________________________________________________________

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#### 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: ________________________________________________________________________________________________

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**NOSE & SINUSES**

- [ ] No problems or deviations assessed

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal drainage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inflamed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polyps/lesions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edema</td>
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</tbody>
</table>

[ ] 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: ________________________________________________________________________________________________

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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: ________________________________________________________________________________________________

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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: ________________________________________________________________________________________________

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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#:  
Unit/Subunit:  
Date:  

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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  [ ] dorsalis 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: __________________________________________________________________________________ (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 ________________________________________________________ (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 ________________________ pounds
[ ] recurrent emesis [ ] rumination ________________________ (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: ____________________________ (location)

[ ] 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: __________________________________________________________________________
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)

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: ________________________________________________________________________________________________
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

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Individual’s Name: ________________________________
Date of Birth: ___________________ Sex: ________
DHS ID#: ___________________________ Date: ____________
Unit/Subunit: __________________________ Date: ____________
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 wheelchair 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: ________________________________

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**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
[ ] Parkinson's
[ ] 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**  
[ ] 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): ______________________________________________________________

**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: 

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Individual’s Name: _________________________________
Date of Birth: _______________________ Sex: __________
DHS ID#: _________________________________________
Unit/Subunit: ____________________  Date: ____________

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N-02-01-11
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