NURSING ASSESSMENT
Sample

INDIVIDUAL	D.O.B.	GENDER	I.D. #
Reason for Assessment: [ ] Initial [ ] Annual [ ] Other:			

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 medications and effectiveness
[ ] Current diet and dietary restrictions
[ ] 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

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):

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: _____
_____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

[ ] 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: _____

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: _____ [ ] presently active [ ] inactive
(description & locations)

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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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 [ ] last dental exam: _____ (date) [ ] dentures

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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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)

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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: _____

Comments: _____

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 [ ] dosalis pedis [ ] posterior tibial

List pulse deviations: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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 _____ 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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

Comments: _____

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 [ ] Esophagogasgtroduodenoscopy (EGD) [ ] Nutritional evaluation

[ ] Weighting schedule change: _____

[ ] Dental consultation to evaluate: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

[ ] 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: _____ (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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
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 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#: _____
Unit/Subunit: _____ Date: _____

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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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

Comments: _____

TARDIVE DYSKINESIA & MOVEMENT DISORDERS [ ] No relevant history
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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

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): _____

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: _____ (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: _____

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____

[ ] 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 DISORDDERS & 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)

Individual's Name: _____
Date of Birth: _____ Sex: _____
DHS ID#: _____
Unit/Subunit: _____ Date: _____