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Patient Assessment Form - Adult

☐ Start of Care ☐ Recertification ☐ Homebound Visit Type: ☐ Home ☐ ATS ☐ PRN ☐ **Patient ID Verified**

Patient Name:	MRN	Age	DOB	Sex ☐ M ☐ F	Date

Source of Information: ☐ Patient ☐ Other:

Reason for Homecare – Primary Diagnosis & Current Home Infusion Medications:

Other Pertinent History and Surgeries: | Primary Language:

Religious/Cultural Practices: | Social/Community Involvement: | Occupation:

Immunizations: ☐ Up-to-date ☐ Other:

Social / Environmental History

Living Situation:
☐ House
☐ Mobile Home
☐ Apartment
☐ Nursing Home
☐ Hotel suite / Efficiency
☐ Other: _____

Marital Status:
☐ Single ☐ Domestic Partner
☐ Married ☐ Widow(er)
☐ Other people living in home:

Home Environment Safety

Suitable for Care: ☐ Yes ☐ No (See Skilled Intervention Note)
☐ Scattered Rugs ☐ Cluttered Living Space/Stairs
☐ Infestation ☐ Unsafe Bathroom
☐ No Smoke Detectors ☐ No Fire Extinguisher
☐ Oxygen used ☐ Unsafe Entry or Exits
☐ No Telephone ☐ Improper Storage of Hazardous Material
Inadequate: ☐ Air ☐ Heat ☐ Plumbing ☐ Electrical ☐ Refrigeration
Comments: _____

Vital Signs

WT Actual:	WT Stated:	**Temp:** ☐ PO ☐ Ax ☐ Other:	**Resp:**	**Heart Rate:**	**B/P:** ☐ RA ☐ LA ☐ Sitting ☐ Lying ☐ Standing

***NPA = No Problem Assessed**

Systems Review

Endocrine

☐ NPA
☐ Diabetes – Type: _____
☐ Current FSBS: _____
☐ Thyroid Disorder: _____
☐ Adrenal Disorder: _____
Pregnant: ☐ Yes ☐ No
☐ Other: _____

Genitourinary

☐ NPA ☐ Urgency
☐ Frequency ☐ Retention
☐ Incontinence ☐ Dysuria
☐ Hematuria # wet diapers/day: _____
☐ Other: _____
☐ Catheter: ☐ Indwelling ☐ Intermittent
☐ External Date Placed: _____
Comments: _____

Cardiovascular

☐ NPA ☐ Cap Refill>3 secs ☐ Abnormal Heart Rhythm
☐ Palpitations ☐ Neck Vein Disten. ☐ Abnormal Hearts Sounds
☐ Tachycardia ☐ Hypertension ☐ Edema
☐ Bradycardia ☐ Hypotension ☐ Pitting: ☐ +1 ☐ +2 ☐ +3 ☐ +4
☐ Angina ☐ Pacemaker Location: _____
☐ Defibrillator ☐ Other: _____

Peripheral Pulses:
RUE: ☐ Present ☐ Absent **RLE:** ☐ Present ☐ Absent: Location: _____
LUE: ☐ Present ☐ Absent **LLE:** ☐ Present ☐ Absent: Location: _____
Comments: _____

Psychosocial

☐ NPA
☐ Alert
☐ Lethargic
☐ Unresponsive
☐ Flat Affect
☐ Agitated
☐ Anxious
☐ Confused

Communication Issues:
☐ NPA
☐ Vision: _____
☐ Hearing: _____
☐ Language/Literacy
☐ Aids Used/Needed: _____
Comments: _____

Speech:
☐ NPA ☐ Slurred
☐ Garbled ☐ Aphasic

Memory:
☐ Good ☐ Fair ☐ Poor

Oriented to:
☐ Person ☐ Place ☐ Time

Comments: _____

Neuromuscular

☐ NPA ☐ Vertigo
☐ Headache ☐ Spasticity
☐ Paresis ☐ Flaccidity
☐ Tremors ☐ ROM Loss
☐ Ataxia ☐ Contractures
☐ Alt. Level of Consciousness (describe):
☐ Paralysis – Level: _____
☐ Seizures (describe): _____
☐ Numbness ☐ CVA ☐ Shunt
☐ Joint Swelling ☐ Joint Stiffness
☐ Other: _____
☐ Sensory Alterations:
☐ Smell ☐ Touch ☐ Taste
Comments: _____

Respiratory

☐ NPA ☐ Orthopnea:
☐ Diminished # pillows _____
☐ Wheezes ☐ Tachypnea
☐ Rhonchi ☐ Stridor
☐ Crackles: ☐ Course ☐ Fine
☐ Dyspnea:
☐ On Exertion ☐ At Rest
☐ Cough:
☐ Productive ☐ Non-Prod.
☐ Sputum (describe): _____
☐ Other: _____
☐ O_2 at: _____ LPM: _____
☐ Continuous ☐ Intermittent
☐ N/C ☐ Mask
DME Co.: _____
Comment: _____

GI/Nutrition

☐ NPA ☐ Abdomen:
☐ Nausea ☐ Vomiting ☐ Taut
☐ Dysphagia ☐ Distended
☐ Constipation ☐ Ascites
☐ Diarrhea ☐ Masses
☐ Bleeding ☐ Tenderness
☐ Ostomy: _____ ☐ ABD Girth:
Last BM: _____ _____
Bowel Sounds: ☐ Present ☐ Absent
☐ Recent Change in Bowel Habits
Diet: _____
Appetite: ☐ Good ☐ Fair ☐ Poor
☐ Enteral Tube Type: _____
☐ Formula: _____
☐ Intermittent: _____
☐ Continuous: _____
☐ Wt Gain/Loss: _____ lbs
Comments: _____

Integumentary

☐ NPA ☐ Dry ☐ Diaphoretic ☐ Pale ☐ Turgor Poor ☐ Rash ☐ Pruritus ☐ Petechiae ☐ Jaundice ☐ Birthmark
☐ Bruises ☐ Abrasion ☐ Incision ☐ Staples ☐ Sutures ☐ Laceration ☐ Pressure Ulcer ☐ Burns
☐ Patient/Caregiver Independent with Wound Care ☐ Wound Managed by: ☐ Wound Clinic ☐ MD Office
☐ Other HHA: _____
☐ SN Performing Wound Care/Assessment (see Wound Addendum) ☐ SN treating active Bleed (see Bleeding Disorder Addendum)
Comments: _____

White - Medical Records Yellow - Patient

Patient Name: _____ **MRN:** _____

Pain

☐ NPA Current Pain Level (0 - 10): _____ Location: _____ Acceptable Pain Level (0 - 10): _____
Pain Description: _____
Relief Measures: _____ Pain Controlled? ☐ Yes ☐ No*
*Intervention: _____

Access Device

Access: ☐ N/A
☐ Peripheral IV start - Attempts x _____ ☐ Peripheral line in place Gauge: _____ Length: _____ Date/Location: _____

☐ PICC or ☐ Midline Site: _____ Type: _____ Lumens: _____
Ext. catheter length: _____cm ☐ Arm Circumference: _____ cm Measurement: 4cm or _____cm above insertion site.
☐ CVAD Site: _____ Type: _____ Lumens: _____ ☐ Tunneled ☐ Non-tunneled
☐ Accessed Port this SNV ☐ Port access in place: Non-coring needle size: _____ gauge _____ inch ☐ Port de-accessed
☐ Subcutaneous ☐ NGT / GT / JT Location: _____ Type: _____ ☐ Other: _____
Access site clean/dry & free of s/sx infection ☐ Yes ☐ No – Describe: _____
☐ Access discontinued – Reason: ☐ Site rotation ☐ Infiltration ☐ Erythema ☐ Leak ☐ Occlusion ☐ Thrombosis ☐ Infusion complete
☐ Therapy concluded ☐ Prescriber order Comments: _____
Dressing / Flush: Access Dressing Change: ☐ N/A ☐ Access flush pre/post med: _____ ml of ☐ NS ☐ D5W
Access flush pre/post lab: ☐ _____ ml NS ☐ Access flush for maintenance: ☐ NS _____ ml ☐ Heparin: _____ ml
Antiseptic Agent: ☐ 3 Alcohol ☐ 3 Betadine ☐ ChloraPrep ☐ Other: _____
Dressing: ☐ Transparent ☐ Gauze & tape ☐ Other: _____ ☐ Antibacterial dressing changed
☐ Securement device changed ☐ Needleless connector changed x _____ Lumens ☐ Extension tubing changed x _____ Lumens
Lab Work: ☐ N/A ☐ BMP ☐ CMP ☐ Pro-time ☐ ESR ☐ Trough ☐ Peak ☐ CBC ☐ Other: _____
Specimen obtained from: ☐ Peripheral Venipuncture ☐ Venous Access Device _____ ml blood discarded
Specimen delivered to: _____

INFUSION RECORD ☐ N/A

☐ **Rx Properly Stored** ☐ **Anaphylaxis Kit Expiration:** _____ ☐ **N/A**
Medication: _____ **Dose:** _____ **Volume:** _____
Medication: _____ **Dose:** _____ **Volume:** _____
Method of administration: ☐ **IVP** ☐ **INJ** ☐ **Gravity-Flow Controlled** ☐ **Pump** ☐ **Disp. Pump** ☐ **Other:** _____
Pump Program #1: _____ **Pump Program #2:** _____
Factor: Lot #: _____ **Exp. Date:** _____ **Labeling checked with orders: SN initial** _____
☐ **Pre-medication (dose & time):** _____

TIME	TEMP	PULSE	RESP.	B/P	RATE	(Patient status / condition / comments)

☐ **Inventory completed:** ☐ **Adequate supplies** ☐ **Ordering** ☐ **Medication Profile Reviewed: No Changes**
☐ **Discharge Plan discussed with patient/caregiver.** **Plan for next visit:** _____

Communication with: ☐ MD ☐ RPh ☐ Other: _____

Skilled Intervention Note: _____

Patient Visit Time: *Start:* _____ *End:* _____ **Lab Time:** *Start:* _____ *End:* _____ **Total Time:** _____

Nurse's Signature **Patient's Signature** **Date**

Patient Education Checklist

Patient Name: _____

Check all applicable content

MRN: _____ SOC Date: _____

Enter service date(s) into columns as appropriate

Therapy: _____

CONTENT	CONTENT DISCUSSED / REVIEWED	ASSISTED RETURN DEMONSTRATION	INDEPENDENT RETURN DEMONSTRATION
☐ **Patient Admission Documents Given/Reviewed:** ☐ Consents ☐ "Getting started with infusion therapy" Booklet ☐ Admission Agreement/Acknowledgement of Receipt of Information ☐ Accreditation information ☐ Home Health Agency state required information (☐ N/A) ☐ Agency 24 Hour Contact #: _____ ☐ Other: _____			
☐ **Review of Disease Process** ☐ **Compliance Needs** ☐ **Patient Education Handouts Given & Reviewed:** ☐ Drug Monograph ☐ Medication Guide ☐ Access Device: _____ ☐ Pump Manual: _____ ☐ IV Access (as needed for IV insertion training) ☐ Other: _____			
Drug / Solution: ☐ Dose: _____ ☐ Schedule: _____ ☐ Label Accuracy ☐ Container Integrity ☐ Inspection of Drug/Solution Storage: ☐ Refrigeration ☐ Room Temp ☐ Protect from light			
Infection Prevention: ☐ Hand Washing ☐ Aseptic Technique ☐ Work Surface Preparation ☐ Device Access / De-access ☐ Blood & Body Fluid Precautions Prepping: ☐ Injection Site(s) ☐ Connectors ☐ Tubing ☐ Needles			
Infusion Access Device Management: ☐ Type / Access: _____ ☐ Clamping ☐ Site Inspection ☐ Patency Check ☐ Flushing ☐ Site Care/Dressing Change ☐ Connector/ Extension Change ☐ PIV Insertion / Removal ☐ Other: _____			
Drug / Solution Preparation: ☐ Premixed ☐ Reconstitution/Transfer ☐ Additives: _____ ☐ Medication-Solution Set-Up ☐ Other: _____			
Administration Method: ☐ IV Push ☐ Gravity ☐ Rate-Flow Controlled Tubing ☐ Disposable Elastomeric ☐ Pump: _____ ☐ Continuous ☐ Intermittent ☐ Cycle/Taper Injection: ☐ Intramuscular ☐ Subcutaneous			
Administration Technique: ☐ Tubing Calibration ☐ Pump Programming ☐ Loading Pump ☐ Filter ☐ Priming Tubing ☐ Batteries ☐ Alarms ☐ Troubleshooting Access Device: ☐ Connect ☐ Disconnect ☐ Other: _____			

White - Medical Records Yellow - Patient Pink - Medical Records

Patient Name: _____ MRN: _____

Potential Complications - Prevention & Intervention: ☐ Infection: ☐ Exit/Injection Site ☐ Systemic ☐ Blood Reflux ☐ Occlusion ☐ Phlebitis ☐ Infiltration ☐ Migration ☐ Break ☐ Thrombus/Embolus ☐ F/E Imbalance ☐ Hyper-Hypoglycemia ☐ Metabolic ☐ Aspiration (oral/enteral) ☐ Nausea/Vomiting ☐ Diarrhea ☐ Adverse Reactions ☐ Anaphylaxis ☐ Hypersensitivity Reaction ☐ Using Epinephrine Autoinjector			
Supplies - Handling / Disposal / Inventory: ☐ Sharps Container ☐ Regular Waste ☐ Narcotics ☐ Hazardous Material ☐ Chemo Precautions ☐ Supply Inventory ☐ Deliveries ☐ Pump Return☐ Other Resources: _____			
Safety: ☐ 911 / EMS ☐ Electrical / Fire ☐ Falls ☐ Travel & Supplies ☐ Other: _____			
Ongoing Monitoring: ☐ Weight: _____ ☐ I&O: _____ ☐ Temp: _____ ☐ Blood Glucose: _____ ☐ Lab Draws: _____ ☐ Appointments: _____ ☐ Other: _____			

Additional Instructions / Comments: _____

Date	Nurse Signature	Date	Nurse Signature

I have received the above information and understand that I will be learning about my disease process, therapy and treatment using the information in the materials that were given to me.

_____
Patient Signature Date

_____ _____
Caregiver Signature (if applicable) Date Caregiver Relationship to Patient

Release of Direct Supervision: I understand that I am now able to perform all of the above listed activities and no longer need the direct supervision of a nurse or pharmacist. I also understand that these skills will be checked by the nurse or pharmacist when needed.

_____
Patient Signature Date

_____ _____
Caregiver Signature (if applicable) Date Caregiver Relationship to Patient

White - Medical Records Yellow - Patient Pink - Medical Records

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PRESCRIBER PLAN OF TREATMENT

PATIENT NAME: _____ **MR#:** _____

SOC Date:	DOB:	Certification Period	From: __/__/____ To: __/__/___
Address: _____ _____ Phone: _____ Cell: _____		Gender: ☐ Male ☐ Female Height: _____ Weight:_____ Allergies:	
Primary Diagnosis:			ICD-10 Code:
Secondary Diagnosis:			ICD-10 Code:
Surgical Procedure:			ICD-10 Code:

ACCESS TYPE

☐Tunneled CVC ☐Non-valved ☐PICC ☐Peripheral
☐Non-tunneled CVC ☐Valved ☐Midline ☐Intrathecal
☐Implanted Port ☐Subcutaneous ☐IM ☐Epidural
Number of Lumens: ☐Single ☐Double ☐Triple
Other:

SKILLED NURSING FREQUENCY ORDERS

☐RN to visit ____ times ☐per week ☐per month for _weeks
☐RN to visit weekly for _____ weeks
☐Number of PRN visits: _____ Reason: _____

ADVANCED DIRECTIVES

DNR Status: ☐Do not resuscitate ☐Patient has advanced directives

VASCULAR ACCESS DEVICE MAINTANENCE ORDERS

Peripheral IV change: ☐Every ____ days ☐PRN ☐With each dose
Non-coring needle change frequency: ☐Weekly and PRN
Injection cap change: ☐ Weekly ☐ ____ times per week and PRN
Extension set change: ☐ Weekly ☐ ____ times per week and PRN
Dressing type: ☐Sterile ☐Occlusive ☐Gauze☐ChloroPrep ☐ETOH/PVI
Change Dressing: ☐Weekly and PRN ☐Every ___ days and PRN ☐Daily
Apply _____ ☐Weekly and PRN ☐PRN ☐With occlusive drsg
Other:

FUNCTIONAL LIMITATIONS

☐Performs daily activities without difficulty ☐Amputation
☐Needs assistance with _____ ☐Paralysis
☐Bowel ☐Bladder incontinence ☐ Contracture
☐Hearing loss ☐ Speech ☐Vision ☐Ambulation
☐Dyspnea with minimal exertion
Unmet spiritual needs: follow up with: _____

TREATMENT ORDERS ☐ See attached medication profile

☐Complete skilled assessment with each visit including instruction regarding disease processes, purpose of therapy, signs and symptoms of potential side effects and response to therapy
☐Instruct patient/caregiver on 24 hour availability of clinical staff, emergency procedures and EMS activation
☐Skilled nurse to administer and/or instruct patient/caregiver in administration of infusion therapy, pump operation, troubleshooting, catheter management, and signs and symptoms related to therapy
☐First Dose: RN to administer, and monitor for adverse reactions
☐Use attached treatment orders PRN for drug reaction. Anaphylaxis – Call 911
☐Remove ☐PICC ☐Non-tunneled CVC when therapy is complete
Apply ☐Pressure dressing ☐Antimicrobial ointment following CVC removal
☐May use Lidocaine 1% 0.1mL to start IV sites for pain management
☐Other:

Plan of Care reviewed with ☐patient ☐caregiver

MENTAL STATUS

☐Oriented ☐Comatose ☐ Disoriented ☐Forgetful
☐Depressed ☐Lethargic ☐Agitated ☐ Other: _____

ACTIVITY ORDERS / SAFETY MEASURES

☐As tolerated ☐No restrictions ☐Bedrest
☐Bedrest / Bathroom only ☐Pt not to lift > 5-10 pounds
Assistive devices: ☐Walker ☐Wheelchair ☐Cane

TEACH PATIENT SAFETY MEASURES

☒Standard precautions ☒Sharps safety ☒Home safety
☒Emergency disaster measures ☒ Medication storage
☒Hazardous waste disposal ☒Electrical safety
Other: _____

REHABILITATION POTENTIAL

☐Poor ☐ Guarded ☐Fair ☐Good ☐Excellent

PROGNOSIS

☐Poor ☐ Guarded ☐Fair ☐Good ☐Excellent

LAB ORDERS

May draw labs from: ☐CVC ☐Peripherally
Labs: _____
Frequency: _____

DME AND SUPPLIES

☐Disposable infusion supplies ☐ Pump
☐IV pole Other: _____

NUTRITION ORDERS

☐Regular ☐Diabetic Other: _____
☐Low Na ☐ Bland _____
☐NPO ☐As tolerated

GOALS/DISCHARGE ORDERS – PATIENT WILL BE DISCHARGED:

☐When independent with self-care
☐When therapy completed ☐When goals are achieved
☐With prescriber follow-up ☐ To assisted living
☐To long term care ☐Other: _____

PRESCRIBER INFORMATION

Name:
Address:
Phone: Fax:

☒I have reviewed this document in full (2 pages) See next page for continued orders)
I hereby ☒certify ☐recertify that the above home infusion and home health services are medically necessary and are authorized by me with a written plan of treatment which will be periodically reviewed by me. This patient is under my care and is in need of the services as indicated.

Prescriber Signature: Date:

RPh Initials: _____

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PRESCRIBER PLAN OF TREATMENT

PATIENT NAME: _____ **MR#:** _____

SKILLED NURSE TO ADMINISTER / INSTRUCT ADMINISTRATION OF:						
START DATE	**STOP DATE**	**NEW OR CHANGED**	**DRUG/CONCENTRATION**	**DOSE**	**FREQUENCY**	**ROUTE**
		☐N ☐C	HEPARIN FLUSH _____UNITS / mL			
		☐N ☐C	0.9% SODIUM CHLORIDE FLUSH			
		☐N ☐C	ANAPHYLXIS KIT		SEE ATTACHED TREATMENT ORDERS	
		☐N ☐C				
		☐N ☐C				
		☐N ☐C				
		☐N ☐C				

MEDICATION PROFILE (List all prescriptions, OTC, herbals and home remedies) ☐ NONE ☐NO OTC/HERBALS OR HOME REMEDIES						
START DATE	**STOP DATE**	**NEW OR CHANGED**	**DRUG/CONCENTRATION**	**DOSE**	**FREQUENCY**	**ROUTE**
		☐N ☐C				
		☐N ☐C				
		☐N ☐C				
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GOALS OF THERAPY	☐ PT/CG INDEPENDENT WITH ALL ASPECTS OF IV / MEDICATION THERAPY ☐PT/CG ABLE TO VERBALIZE SIGNS AND SYMPTOMS TO REPORT ☐PT/CG ABLE TO VERBALIZE SIDE EFFECTS OF MEDICATION (CHECKED BOX INDICATES ACHIEVED) ☐VASCULAR ACCESS WILL REMIN PATENT AND FREE OF COMPLICATIONS ☐PATIENT WILL TOLERATE THERAPY WITHOUT ADVERSE EFFECTS
60 DAY SUMMARY	☐**NA**

NURSE'S SIGNATURE:	**DATE:**	**VERBAL SOC DATE:**

RPh Initials: _____

ROYAL QUALITY NURSING SERVICES, INC.

PATIENT: _____ DIAGNOSIS: _____

NURSING CARE PLAN

Patient Problem (Check all that apply)	Nursing Intervention (Check all that apply)	Desired Outcomes/End Goals (Check all that apply)
1. Identified by _____ RN Date: _____ ___ Knowledge deficit as related to the purpose, indications, management of home therapy: (Circle one) ABT ST IVIG HYD LAB CC Other: _____	_Nurse will provide patient/caregiver education by explanation, discussion, demonstration and handouts.	Patient/Caregiver will be able to: _ Verbalize understanding of purpose and goals of prescribed therapy/treatment _Verbalize understanding of complications/problems and their interventions Independent Administration of prescribed regimen: _ SASH _ Saline Only _ Heparin Only _Safely operate device: (Specify) _____ _____
2. Identified by _____ RN Date: _____ _ Potential for complications related to non-compliance	_ Nurse will review with patient/caregiver the prescribed regimen.	Patient/Caregiver will be compliant with prescribed therapy evidenced by: _ Desired outcomes. _ Progression to goals.
3. Identified by _____ RN Date: _____ _ Potential for Adverse Drug Reactions	_ Nurse will review with patient/caregiver possible signs/symptoms of adverse reactions related to the prescribed drug regimen.	Patient/Caregiver will be able to: _ Verbalize understanding of possible signs/symptoms of adverse reactions
4. Identified by _____ RN Date: _____ _ Alteration in comfort (pain) related to (Specify) _____	_ Nurse will assess patient's pain each visit. _ Nurse will review patient's prescribed pain control regimen	Patient will obtain optimal level of comfort evidence by: _ Verbalizing pain free. _Verbalizing improvement of pain (pain at a manageable level)
5. Identified by _____ RN Date: _____ _ Fluid Volume Excess/Deficit	Nurse will monitor: _ Vital Signs (Orthostatic BP necessary for all patients receiving hydration.) _ Weight _ Intake & Output _ Electrolytes	Patient will maintain fluid volume balance evidenced by: _ Normal Vital Signs _ Adequate urinary output _ Normal Electrolyte levels

ROYAL QUALITY NURSING SERVICES, INC.

PATIENT: _____ DIAGNOSIS: _____

NURSING CARE PLAN

6. Identified by _____ RN Date: _____ _ Alteration in nutrition less than body requirements related to inadequate nutrient intake/disease process.	_ Nurse will provide patient education by explanation, discussion, demonstration and handouts. Nurse will monitor: _ Vital Signs _ Weight _ Intake & Output _ Electrolytes	Patient will achieve and maintain acceptable level of nutrition as evidenced by: _ Weight gain/loss _ Maintenance of acceptable nutritional parameters including ordered laboratory test/values.
7. Identified by _____ RN Date: _____ _ Potential for infection Access site: PICC Periph. Port Hickman/Groshong	_ Nurse will assess access site as prescribed by MD _ Nurse will review with patient/caregiver: signs and symptoms of infection	Patient will remain infection free as evidenced by: _Normal temperature: < 100 F _ No redness, pain or drainage at access site
8. Identified by _____ RN Date: _____		
9. Identified by _____ RN Date: _____		

Reviewed Date: _____ by _____ RN
Reviewed Date: _____ by _____ RN

I have had an opportunity to discuss my care and treatment in the development of this plan of care and approve of the care prescribed.
Patient/Caregiver _____
Initiated by _____