GOLDEN SUNRISE NUTRACEUTICAL, INC.
219 N. "E" Street * PORTERVILLE, CA 93257
Phone No.: 1.559.781.0658 Fax No.: 1.559.615.1268

SKILLED INTAKE CLINICAL ASSESSMENT DATA

PATIENT NAME:	**Age:**
	DOB:
NAME of PHYSICIAN:	**Gender:**
	Ethnicity:
ALLERGIES:	**Height:** **Weight:**
DIAGNOSIS:	

VITAL SIGNS	BP:_____ ( ) L ( ) R ( ) sitting ( ) lying down ( ) stable V/S HR:_____ ( ) regular ( ) irregular RR:_____ ( ) regular ( ) irregular Temp:_____ ( ) oral ( ) axillary ( ) temporal ( ) Other:_____ **PAIN STATUS:**_____ *Pain Location:*_____ *Pain Frequency:* ( ) constant ( ) on/off *Pain Characteristics:* ( ) sharp ( ) stabbing ( ) vague ( ) gnawing ( ) other:_____ *Pain worsened by:* ( ) rest ( ) activity *Pain relieved by:* ( ) rest ( )movement ( ) pain Meds:_____
GENERAL CONDITION	( ) alert ( ) oriented ( ) disoriented ( ) time ( ) person ( ) place ( ) confused ( ) forgetful ( ) occasional confusion ( ) occasional disorientation ( ) dementia ( ) alzheimer's ( ) lethargic ( ) vegetative state ( ) fatigue/lethargic ( ) non-verbal ( ) other:
HOMEBOUND REASON	( ) Needs assistance for all ADL? ( ) Yes ( ) No
MOBILITY STATUS	( ) poor balance ( ) unsteady gait ( ) BKA / AKA / amputed toes ( ) with assistive device ( ) chair / wheelchair bound ( ) bed bound ( ) other:
LIVING SITUATION	( ) lives alone ( ) with spouse ( ) with family member:_____ ( ) other:_____ ( ) lives at own house ( ) apartment ( ) assisted living ( ) senior apartment ( ) other:
CAREGIVING SITUATION	( ) on CG ( ) spouse ( ) family member:_____ ( ) neighbor ( ) paid help ( ) limited availability ( ) available as needed ( ) overwhelmed ( ) poor health ( ) other:
CARDIOVASCULAR STATUS	( ) palpitations ( ) w / activity ( ) at rest ( ) dizziness / vertigo ( ) pacemaker ( ) chest pain ( ) w / activity ( ) at rest ( ) hx of cardiac surgery ( ) no problem ( ) other:

Patient Name / Signature / Date:	***Staff Name / Title / Signature / Date:***	***Date:*** ***Time In:***_____ ***Time Out:***_____

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PERIPHERAL CIRCULATION	( ) pedal pulse dim ( ) R ( ) L ( ) leg pain ( ) R ( ) L ( ) swelling ( ) R ( ) L ( ) pedal pulse absent ( ) R ( ) L ( ) numbness ( ) R ( ) L ( ) discoloration ( ) R ( ) L ( ) tingling ( ) R ( ) L ( ) no problem ( ) gangrene ( ) R ( ) L ( ) redness / bluish ( ) R ( ) L ( ) pitting edema ( ) R ( ) L ( ) +1 ( ) +2 ( ) +3 ( ) +4 ( ) other:
PULMONARY STATUS	( ) clear breath sounds ( ) SOB / DOE ( ) uses nebulizer ( ) rales / wheezing ( ) orthopnea ( ) tracheostomy ( ) cough ( ) uses oxygen ( ) pulse oxi reading:_____ ( ) other:
NEUROLOGIC STATUS	( ) R/L sided weakness / paralysis ( ) paraplegic ( ) quadriplegic ( ) headache ( ) aphasia ( ) facial asymmetry ( ) seizure disorder ( ) tremors at rest / activity ( ) no problem ( ) other:
ENDOCRINE STATUS	( ) FBS:_____ ( ) BG checked by: ( ) PT ( ) CG ( ) SN ( ) unable to check BS ( ) other:
GASTROINTESTINAL NUTRITIONAL STATUS	( ) good / poor appetite ( ) dehydrated ( ) Jackson - Pratt ( ) nausea / vomiting ( ) distended abdomen ( ) bowel incontinence ( ) diarrhea_____ ( ) epigastric discomfort ( ) constipated: Last BM_____ ( ) GT / JT with or without feed ( ) weight loss:_____ ( ) colostomy / other drainage ( ) no problems ( ) other:
GENITO - URINARY STATUS	( ) burning ( ) dribbling ( ) stress / urge incontinent ( ) frequency:_____ ( ) foley catheter ( ) urostomy ( ) condom catheter ( ) suprapubic catheter ( ) recurrent UTI ( ) hematuria ( ) cloudy urine ( ) urine sediment ( ) dark / blackish urine ( ) peritoneal / hemodialysis ( ) frequency_____ ( ) no problem ( ) other:
INTEGUMENTARY STATUS	( ) surgical wound ( ) open wound ( ) pressure ulcer ( ) diabetic ulcer ( ) stasis ulcer ( ) rash ( ) cellulitis ( ) see wound description on wound sheet ( ) other:

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MUSCULO-SKELETAL STATUS	( ) joint swelling ( ) BKA / AKA / amputated toes ( ) S/P surgery ( ) fracture ( ) weakness of UE / LE ( ) hip ( ) deformity ( ) leg cramps ( ) knee ( ) Hx of fall ( ) no problem ( ) other surgeries:_____ ( ) others:
ASSESSMENT PERFORMED	( ) head to toe assessment ( ) assessed pain status ( ) assessed knowledge of blood sugar monitoring ( ) assessed safety ( ) assessed knowledge of insulin administration ( ) assessed knowledge of prior teaching ( ) assessed blood sugar logs taken by patient / CG ( ) assessed Meds compliance ( ) assessed knowledge of diabetic regimen ( ) assessed diet and compliance ( ) assessed S / SX of hyper / hypoglycemia ( ) assessed caregiving status ( ) assessed wound care techniques ( ) assessed infection control measures ( ) assessed colostomy status ( ) assessed wound healing / complications ( ) assessed foley / urostomy drainage and maintenance ( ) other assessment findings:
OTHER PERTINENT FINDINGS / NOTES	
TEACHINGS / INSTRUCTIONS PERFORMED	( ) medications ( ) fingerstick blood sugar monitoring ( ) disease process of :_____ ( ) administration of insulin ( ) complications of:_____ ( ) S / SX of hyper / hypoglycemia ( ) S / SX to observe and report:_____ ( ) pain management techniques ( ) ER / 911 protocol ( ) pacemaker protocol ( ) infection control measures ( ) coumadin precaution ( ) proper disposal of sharps ( ) energy conservation technique ( ) proper disposal of solid dressing ( ) colostomy / ileostomy management ( ) skin care / foot care regimen ( ) catheter / urostomy management ( ) prevention of decubitus ulcers ( ) incontinent care ( ) how to perform wound care ( ) GT / JT flushing and site care ( ) diabetic diet ( ) traceheostomy care ( ) diabetic sick day rules ( ) oxygen use and care ( ) S / SX of heart attack ( ) measures to prevent falls ( ) S / SX of impending CVA ( ) S / SX of GI bleeding ( ) other:

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TEACHINGS GIVEN TO:	( ) patient ( ) caregiver:_____ ***METHODS:*** ( ) verbal ( ) demonstration ( ) hands out ( ) video tape ( ) other:
OUTCOME OF TEACHINGS:	( ) verbalized full understanding ( ) good return demonstration ( ) verbalized partial understanding ( ) other:
PROGRESS TOWARDS ACHIEVEMENT OF GOALS (done at least weekly)	( ) medical condition stable ( ) pain not yet resolved ( ) foley catheter assessment still needed ( ) still with open wound ( ) GT / JT assessment still needed ( ) wounds resolved ( ) colostomy assessment still needed ( ) compliance improved through teachings ( ) pain not yet resolved ( ) UNSTABLE (see assessment findings) ( ) pain / CG still needs instructions ( ) vital signs ( ) GI status ( ) SN supervision needed for Meds management ( ) cardiac status ( ) GU status ( ) PT / CG unable to perform procedure without SN ( ) neuro status ( ) diabetic status ( ) new / recent change in Meds ( ) respiratory status ( ) musculoskeletal status ( ) other:
CURRENT MEDICATIONS	
PAST MEDICAL HISTORY	

PROGRESS NOTES

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