

SKILLED INTAKE CLINICAL ASSESSMENT DATA

PATIENT NAME:		Age:
NAME of PHYSICIAN:		DOB:
ALLERGIES:		Gender:
		Ethnicity:
		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: _____ <i>Pain Location:</i> _____ <i>Pain Frequency:</i> () constant () on/off <i>Pain Characteristics:</i> () sharp () stabbing () vague () gnawing () other: _____ <i>Pain worsened by:</i> () rest () activity <i>Pain relieved by:</i> () 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 / amputated 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:	
<i>Patient Name / Signature / Date:</i>		<i>Staff Name / Title / Signature / Date:</i>
		<i>Date:</i>
		<i>Time In:</i> _____
		<i>Time Out:</i> _____

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

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

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

PROGRESS NOTES	

<p><i>Patient Name:</i></p>	<p><i>Staff Name:</i></p>
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