PEDIATRIC SOC EVALUATION ASSESSMENT

☐ PT ID PERFORMED VIA NAME, DOB, FACE RECOGNITION AND ADDRESS BEFORE SERVICE PROVIDED SG

NAME _____

NUMBER _____

DEMOGRAPHICS

PATIENT NAME | ADDRESS/CITY/STATE/ZIP | TELEPHONE

DATE OF BIRTH | AGE/SEX/RACE | NICKNAME

EMERGENCY CONTACT | ADDRESS/CITY/STATE/ZIP | TELEPHONE (DAY-NIGHT)

MOTHER | ADDRESS/CITY/STATE/ZIP | TELEPHONE (DAY-NIGHT)

FATHER | ADDRESS/CITY/STATE/ZIP | TELEPHONE (DAY-NIGHT)

PHYSICIAN | ADDRESS/CITY/STATE/ZIP | TELEPHONE

HOSPITAL | ADDRESS/CITY/STATE/ZIP | DATES OF STAY

PARENTS EMPLOYER | ADDRESS/CITY/STATE/ZIP | TELEPHONE

REFERRAL SOURCE | ADDRESS/CITY/STATE/ZIP | TELEPHONE

BILLING

SOCIAL SECURITY NO. | AGENCY NO.

MEDICARE NO. | MEDICAID NO.

OTHER INSURANCE | GROUP NAME | NUMBER

PRIMARY PAYOR _____ MEDICARE _____ MEDICAID _____ OTHER INSURANCE

INSURED'S NAME | RELATION TO PT. | EMPLOYER

STUDENT _____YES _____ NO GRADE _____

SCHOOL _____

CLINICAL DATA

PRIMARY DX | ICD-10 | ONSET DATE

SECONDARY DX | ICD-10 | ONSET DATE

OTHER DX | ICD-10 | ONSET DATE

RELEVANT SURGERY | ICD-10 | DATE

BIRTH RELATED? _____YES _____NO

ACCIDENT RELATED? _____YES _____NO

DATE PLAN ESTABLISHED | ADM DATE | DATE CARE BEGAN

SOCIOECONOMIC PROFILE

PRIMARY CAREGIVER

NAME _____

RELATIONSHIP _____ PARENT _____ FRIEND/RELATIVE

_____HIRED ATTENDANT _____OTHER (Specify)

_____WILLING _____HESITANT _____UNWILLING

_____NOT PAID _____PAIL)

_____AVAILABLE AS NEEDED _____ LIMITED AVAILABILITY

HEALTH: _____GOOD _____ FAIR _____ POOR

RESIDENCE/ LIVING ARRANGEMENT/ SAFETY

_____OWN HOME_____ANOTHER'S HOME_____

_____SIBLINGS (NAME/AGE)_____

_____SAFE ENVIRONMENT _____UNSAFE (Specify)_____

_____INTERCOM _____SMOKE DETECTOR_____

IS ENVIRONMENT SUITABLE FOR TYPE, AMOUNT, LEVEL OF CARE ORDERED?

_____YES _____NO

ADDITIONAL INFORMATION _____

NUTRITION

TYPE OF DIET: _____ REG_____OTHER (Specify)_____

FORMULA (TYPE/AMT. FREQ.) _____

INFUSION THERAPY _____NO _____YES (Describe)_____

FEEDING TUBE: ___ NO _____ YES (Describe) _____

FOOD ALLERGY: _____NO _____YES (Specify) _____

NO. OF MEALS/DAY_____ FAVORITE MEAL _____

LIKES _____

DISLIKES _____

ADEQUATE FOOD INTAKE _____YES _____ NO

ADEQUATE FLUID INTAKE _____YES _____ NO

DESCRIBE NUTRITIONAL HABITS _____

HOMEBOUND STATUS/ AMBULATION

ASSISTANCE REQUIRED: _____ MIN _____MOD. _____ MAX.

CONFINED TO BED: _____NO _____YES

REQUIRES HUMAN ASSISTANCE TO AMBULATE: _____NO _____YES

WHEELCHAIR/CANE/WALKER USE: _____NO _____YES

OXYGEN USE,_____NO _____YES OTHER DEVICE _____

FINANCIAL INFORMATION

_____SALARY INCOME _____SOCIAL SECURITY/MEDICAID

_____INCOME ADEQUATE _____ INADEOUATE

OTHER AGENCY ASSISTING PATIENT (CONTACT It PHONE)

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PROGNOSIS:
❑ 1-Poor ❑ 2-Guarded ❑ 3-Fair ❑ 4-Good ❑ 5-Excellent

CLINICAL INFORMATION /HISTORY

PERTINENT HISTORY OF PRESENT ILLNESS _____

PAST ILLNESS (Include Mumps, Measles, Chicken Pox, Flu, Scarlet Fever, Whooping Cough) — DATE OF OCCURRENCE

SURGERY — DATE OF OCCURRENCE

ALLERGIES: _____NO _____YES (Specify)_____

IMMUNIZATIONS' _____ CURRENT _____ NEEDS (Specify) _____

(DPT,TB, Rubeola, Rubella, Polio, HIB) _____

PERTINENT FAMILY HISTORY _____

TB TEST DATE/RESULTS _____

MEDICATION/DOSE/ROUTE

HOSPITALIZATIONS, DOCTOR VISITS — DATE

SENSORY SYSTEM REVIEW

VISION _____NORMAL _____ABNORMAL
HEARING _____NORMAL _____ABNORMAL
SPEECH (For Age) _____NORMAL _____ABNORMAL
SMELL _____NORMAL _____ABNORMAL
TASTE _____NORMAL _____ABNORMAL
EYEGLASSES _____YES _____NO HEARING AID _____YES _____NO
ADDITIONAL PERTINENT INFORMATION _____

SENSORY CLINICAL FINDINGS

EYE EXAMINATION _____NORMAL _____ABNORMAL
EAR EXAMINATION _____NORMAL _____ABNORMAL
NOSE EXAMINATION _____NORMAL _____ABNORMAL
THROAT EXAMINATION _____NORMAL _____ABNORMAL
MOUTH EXAMINATION _____NORMAL _____ABNORMAL
ADDITIONAL PERTINENT INFORMATION _____

NEUROLOGICAL/ MENTAL SYSTEM REVIEW

CONSCIOUSNESS _____NORMAL _____ABNORMAL
ALERTNESS _____NORMAL _____ABNORMAL
VERBAL RESPONSES (For Age) _____NORMAL _____ABNORMAL
RESPONSE TO COMMAND _____NORMAL _____ABNORMAL
MEMORY (For Age) _____NORMAL _____ABNORMAL
SLEEP PATTERNS _____NORMAL _____ABNORMAL
SEIZURES _____NO _____YES
NAPS _____NO _____YES
NAP TIMES _____
BEDTIME _____
ADDITIONAL PERTINENT INFORMATION _____

NEUROLOGICAL/MENTAL CLINICAL FINDINGS

ORIENTATION _____P.P.T. _____NORMAL _____ABNORMAL
PUPIL RESPONSES _____LEFT _____NORMAL _____ABNORMAL
RIGHT _____NORMAL _____ABNORMAL
GRIP _____LEFT _____NORMAL _____ABNORMAL
RIGHT _____NORMAL _____ABNORMAL
REFLEXES _____LEFT _____NORMAL _____ABNORMAL
RIGHT _____NORMAL _____ABNORMAL
CO-ORDINATION _____NORMAL _____ABNORMAL
BALANCE _____NORMAL _____ABNORMAL
PAINISTIMULI RESPONSE _____NORMAL _____ABNORMAL
OTHER _____ _____NORMAL _____ABNORMAL
ADDITIONAL PERTINENT INFORMATION _____

GENITOURINARY/ELIMINATION

TOILET TRAINED _____NO _____YES
DIAPERS _____NO _____YES
FOLEY CATHETER _____NO _____YES
COLOSTOMY _____NO _____YES
HERNIA _____NO _____YES
WORDS FOR ELIMINATION _____
DESCRIBE TOILET HABITS _____

GROWTH AND DEVELOPMENT

PHYSICAL DEVELOPMENT _____NORMAL _____ABNORMAL
MOTOR DEVELOPMENT _____NORMAL _____ABNORMAL
NEUROLOGICAL DEVELOPMENT _____NORMAL _____ABNORMAL
HEAD CIRCUMFERENCE (INFANT) _____
HEIGHT _____WEIGHT _____
DESCRIBE DEVELOPMENTAL DELAYS/ABNORMALITIES _____

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SAFETY MEASURES / LIVING ARRANGEMENTS / SUPPORTIVE ASSISTANCE

Safety Measures: CMS485-POC

- ❑ Cast Precautions
- ❑ Change position slowly
- ❑ Coumadin/Heparin Precautions
- ❑ Bleeding Precautions
- ❑ Good handwashing technique
- ❑ Oxygen Precaution/Fire prevention SG
- ❑ Practice Universal Precautions
- ❑ Do not lift, bend, stoop
- ❑ Respiratory Precautions
- ❑ Diabetic Precautions
- ❑ Wound/Decubitus precautions
- ❑ Adequate lighting
- ❑ Prevent Cardiac Overload
- ❑ Prevent Falls and Injuries SG
- ❑ Safe Ambulation
- ❑ Prev. Infection Complications
- ❑ Seizure Precautions
- ❑ Suicide precautions
- ❑ Support due functional limitation
- ❑ Teach coping skills
- ❑ Safe storage/disposal syringes
- ❑ G.I. Precautions
- ❑ G.U. Precautions
- ❑ Safe Transfers
- ❑ SAN Precautions
- ❑ Catheter Care
- ❑ Provide Emotional Support
- ❑ Emergency Plan
- ❑ Cardiac Precautions
- ❑ Maintain Safe/clear Environment
- ❑ Maintain Good Skin care
- ❑ Clear pathways
- ❑ Correct handwashing technique SG
- ❑ Check bathroom, floor/stairs for safety hazards
- ❑ Psycho-social, behavior precautions
- ❑ Other: _____

HOME ENVIRONMENT SAFETY

Safety hazards in the home: (check all that apply)

SG	Fire alarm/smoke detector /Fire extinguish	❑Y ❑N
	Inadequate heating/ cooling/ electricity / lighting	❑Y ❑N
	Hurricane, Disaster Emergency supplies/kits	❑Y ❑N
	First aid box/Emergency Equipment or Supplies	❑Y ❑N
SG	Unsafe gas/electrical appliances or electrical outlets	❑Y ❑N
	Inadequate running water, plumbing problems	❑Y ❑N
	Unsafe storage of supplies/ equipment/ HME	❑Y ❑N
	No telephone available and/or unable to use the phone	❑Y ❑N
	Pest problems, Insects/rodents	❑Y ❑N
SG	Medications stored safely, clearly-easy use, check interactions	❑Y ❑N
	Emergency planning, Exit Plan in place, more than one exit	❑Y ❑N
	Enough Ventilation	❑Y ❑N
	Safe Beds/Chairs, clear pathways	❑Y ❑N
	Able to follow directions in case of Emergency	❑Y ❑N
SG	Slippery Floors, Ashtrays (if a smoker)	❑Y ❑N
	Plan for power failure, emergency lights, flashlights, etc.	❑Y ❑N
	Relevant medical appliances, if applicable (wheelchair, O_2, Monitors, etc.)	❑Y ❑N
	Hurricane Shutter , Disaster Plan	❑Y ❑N

Oxygen use: Signs posted ❑Y ❑N ❑Oxygen Precautions explained

Follow smoking /flammables safety precautions: ❑Y ❑N SG

Oxygen back-up: ❑ Available ❑ Knows/ Instructed how to use

Plan/Comments: _____

Instructions/Information Provided, Sign Up package (Check all that apply):

- ❑ Patient Rights and responsibilities
- ❑ Do not resuscitate (DNR) (if applicable)
- ❑ State hotline/ABUSE number
- ❑ Service Agreement/Contract
- ❑ Advance directives information
- ❑ OASIS/HIPAA Privacy Notice, Confidentiality
- ❑ Emergency Plan, classification, instructions
- ❑ Medication sheet, reconciliated/checked SG
- ❑ Agency phone numbers, address
- ❑ Home safety guidelines
- ❑ Client Information Handbook
- ❑ Alzheimer's, Sensory impairments info
- ❑ Pain Management info
- ❑ Grievance Procedures
- ❑ Standard precautions /handwashing/ Infection Control SG
- ❑ Admission criteria, Information for Home visit, Services, Frequency
- ❑ Diabetes Control, other disease management information
- ❑ Care Plans ❑ Local Resources Guide ❑ Mission, ownership information
- ❑ Fall Prevention Program SG ❑ Other: _____

APPLIANCES/ SPECIAL EQUIPMENT/ HOME MEDICAL EQUIPMENT (HME)

- ❑ Brace/Orthotics (specify) _____
- ❑ Transfer equipment: Board/Lift ❑ Bedside commode
- ❑ Ostomy Pliers ❑ Shower chair ❑ Scooters ❑ Hoists
- ❑ Prosthesis: RUE /RLE /LUE/LLE/Other _____
- ❑ Grab bars: Bathroom/Other _____
- ❑ Hospital bed: Semi-elec. /Crank/ Spec. _____
- ❑ Lifeline ❑ Wheeled Walker ❑ Other: _____ ❑ N/A

- ❑ Other HME/needs (specify) _____
- ❑ Oxygen: HME Co. _____
- ❑ Fire Prevention/Safety Program in place, Patient instructed SG

HME Rep. _____ Phone _____ ❑N/A

- ❑ Organizations providing Home Medical Equipment (HME):

Phone _____ ❑ N/A

INFUSION / IV THERAPY

❑ **N/A** ☐ **Infusion / IV Therapy order obtained, verified**

❑ Peripheral line ❑ Central line ☐ Medline catheter

Type/brand _____

Size: _____ Gauge: _____ Length: _____

❑ Groshong ❑Non-Groshong ❑ Tunneled ❑ Non-tunneled

Insertion site _____ Insertion date _____

Lumens: ❑ Single ❑ Double ❑ Triple

Flush solution: _____ Frequency: _____

Dressing change frequency _____ ❑ Sterile ❑ Clean

Performed by: ❑ Physician ❑ RN ❑ Caregiver ❑ Other: _____

Site/skin condition _____

Comment: _____

- ❑ Pump: (type, specify) _____

Administered by: ☐ Physician ❑ Caregiver ❑ RN ❑ Other _____

Purpose of Intravenous Access: ❑ Lab draws _____

- ❑ Antibiotic therapy _____ ❑ Expand intravascular volume
- ❑ Chemotherapy ❑ Maintain venous access ❑ Pain control
- ❑ Hydration ❑ Parenteral nutrition (TPN) ❑ **N/A**
- ❑ Blood and its derivatives ❑ Other _____

- ❑ Infusion care provided during visit _____

Interventions/ Instructions/ Comments/ Problems Detected:

Removing line date (if know): _____ ❑ **N/A**

NAME _____

NUMBER _____

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RESPIRATORY SYSTEM REVIEW

DYSPNEA _____ NO YES
SHORTNESS OF BREATH _____ NO YES
WHEEZING _____ NO YES
COUGH _____ NO YES
BREATH SOUNDS _____ RIGHT UPPER NORMAL ABNORMAL
RIGHT LOWER NORMAL ABNORMAL
LEFT UPPER NORMAL ABNORMAL
LEFT LOWER NORMAL ABNORMAL
DESCRIBE _____

O2 USE NO YES TYPE LITERS/MIN.
OTHER RESR EOUIP.(APNEA MONITOR/VENTILATOR) _____
BACK-UP GENERATOR, MONITOR, VENTILATOR _____
ADDITIONAL PERTINENT INFORMATION _____

INTEGUMENTARY SYSTEM REVIEW

PERSPIRATION _____ NORMAL ABNORMAL
ITCHING _____ NO YES
RASH _____ NO YES
PAIN _____ NO YES
COLOR _____ NORMAL ABNORMAL
TURGOR _____ NORMAL ABNORMAL
TEMPERATURE _____ NORMAL ABNORMAL
'DRYNESS _____ NORMAL ABNORMAL
HAIR _____ NORMAL ABNORMAL
OPEN WOUNDSfULCERS _____ NO YES
SCARS _____ NO YES
PALPABLE NODES _____ NO YES
ADDITIONAL INFORMATION (DIAGRAM ON BACK)' _____

CARDIOVASCULAR CLINICAL FINDINGS/VITAL SIGNS

TEMPERATURE ORAL RECTAL AXILLARY
BLOOD PRESSURE RIGHT LEFT
SITTING _____ / _____ / _____
STANDING _____ / _____ / _____ IF NECESSARY
LYING _____ / _____ / _____ IF NECESSARY
RESPIRATION _____ REGULAR IRREGULAR
APICAL PULSE RATE _____
RADIAL PULSE RATE RIGHT _____ LEFT _____
PEDAL PULSES RIGHT _____ LEFT _____
HEART SOUNDS _____ NORMAL _____ ABNORMAL (Describe)
EDEMA _____ NO YES
BRUISING _____ NO YES
LEG PAIN _____ NO YES
ARM PAIN _____ NO YES
OTHER _____ NO YES
OTHER _____ NO YES
DOITIONAL PERTINENT INFORMATION _____

ENDOCRINE SYSTEM REVIEW

POLYURIA _____ NO YES
POLYPHAGIA _____ NO YES
POLYDIPSIA _____ NO YES
WEIGHT GAIN _____ NO YES
WEIGHT LOSS _____ NO YES
THYROID PALPATION _____ NORMAL ABNORMAL
URINALYSIS _____ ACETONE NO YES
GLUCOSE NO YES
EXOPTHALMOS _____ NO YES
OTHER (SPECIFY) _____ NO YES
ADDITIONAL PERTINENT INFORMATION _____

MUSCULOSKELETAL SYSTEM REVIEW

STRENGTH _____ NORMAL ABNORMAL
CO-ORDINATION _____ NORMAL ABNORMAL
JOINT/MUSCLE PAIN _____ NO YES
SWOLLEN JOINTS _____ NO YES
BACK PAIN _____ NO YES
ROM HEAD/NECK _____ NORMAL ABNORMAL
ROM UPPER EXT _____ NORMAL ABNORMAL
ROM LOWER EXT _____ NORMAL ABNORMAL
POSTURE _____ NORMAL ABNORMAL
MUSCLE TONE _____ NORMAL ABNORMAL
OTHER _____ NORMAL ABNORMAL
ADDITIONAL PERTINENT INFORMATION _____

DIGESTIVE SYSTEM REVIEW

CHEWING _____ NORMAL ABNORMAL
SWALLOWING _____ NORMAL ABNORMAL
APPETITE _____ NORMAL ABNORMAL
BOWEL MOVEMENTS _____ NORMAL ABNORMAL
NAUSEA _____ NO YES
VOMITING _____ NO YES
SUCKING _____ NORMAL ABNORMAL
TONGUE _____ NORMAL ABNORMAL
TEETH _____ NORMAL ABNORMAL
GUMS/ORAL MUCOSA _____ NORMAL ABNORMAL
ABDOMINAL PALPATION _____ NORMAL ABNORMAL
BOWEL SOUNDS _____ NORMAL ABNORMAL
LIVER PALPATION _____ NORMAL ABNORMAL
UMBILICAL HERNIA _____ NO YES
ADDITIONAL PERTINENT INFORMATION _____

FUNCTION AND KNOWLEDGE ASSESSMENT

ACTIVITIES OF DAILY LIVING	Independent	Needs Assist	Fully Depend
CRAWLING (INFANT)			
WALKING			
DRESSING			
BATHING			
FEEDING			
TOILETING			

KNOWLEDGE	Yes	No	Not Appli.
UNDERSTANDS DIAGNOSIS			
UNDERSTANDS PROGNOSIS			
UNDERSTANDS MED REGIME			
UNDERSTANDS COMPLICATIONS			
OTHER			
OTHER			

ADDITIONAL INFORMATION *(USE EXTRA SHEET AS NEEDED)* _____

SIGNATURE _____ DATE _____

REVIEW/ASSESSMENT - SIGNATURE _____ DATE _____