SG Safety Goal
# POC (CMS - 485) Box

Clear Form

# COMPREHENSIVE ADULT SOC ASSESSMENT
## WITH CMS 485 (POC) INFORMATION

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

**(M0030) Start of Care Date:** __/__/____ (month / day / year) 2

**Certification Period:** 3

From __/__/____ To__/__/____

TIME IN _____ TIME OUT _____

DATE ____/____/____

**Provider Number:** _____ 5

Agency Name:_____ 7

**Physician name:** _____

Phone: _____

Address: _____ 24

Employee's Name/Title Completing the Assessment:

Phone Number: _____

_____

**PHYSICIAN:** Date last contacted: ___/___/____ Date last visited: ___/___/____ Reason: _____

**Other Physician** (if any): _____

Address: _____

Phone Number: _____

REFERRAL SOURCE (if not from Primary Physician): Referral date: ___/___/____

☐ N/A

Phone:_____ Fax: _____

**Patient ID Number:** _____ 4
**(Medical Record)**

6 **Patient Name:**_____

Address: _____

6 _____

Patient Phone: _____ ☐ ALF / AFHC (circle)

**Social Security Number:** _____ Name: _____

1 Phone: _____

**Medicaid Number:** _____ 1

**Birth Date:** __/__/____ **Gender:** ○ Male ○ Female 9
8 month / day / year

**Emergency/Disaster Plan Classification Code:** _____

**EMERGENCY CONTACT:** _____

Address: _____

Phone: _____ Relationship: _____

OTHER: _____

Evacuation Form needed? Emergency Registration Completed (please document)

RECENT HOSPITALIZATION? ○ No ○ Yes, dates ____ - ____

Reason: _____

New diagnosis/condition? ○ No ○ Yes, specify _____

**IMMUNIZATIONS:** ☐ Up-to-date ☐ H1N1

Needs: ☐ Influenza ☐ Pneumonia ☐ Tetanus ☐ Other (specify) _____

CHIEF COMPLAINT: _____

PRESENT ILLNESS/DIAGNOSIS: _____

PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES: ☐ Diabetes
☐ Hypertension ☐ Cardiac ☐ Respiratory ☐ Osteoporosis ☐ Insulin Dependent
☐ Fractures: _____ ☐ Cancer (site: _____) ☐ Non Insulin Dependent
☐ Immunosuppressed ☐ Open Wound ☐ Surgeries: _____
☐ Other: _____ ☐ Infection

PREVIOUS OUTCOMES: _____

**VITAL SIGNS:**

**Blood Pressure:** ☐ Sitting/lying R _____ L _____
☐ Standing R _____ L _____ ☐ Rest ☐ Activity ☐ Cheynes Stokes

**Temperature:** _____
☐ Oral ☐ Axillary ☐ Rectal ☐ Tympanic

**Pulse:** ☐ Apical _____ ☐ Brachial ☐ Radial _____ ☐ Carotid _____

**Respirations:** _____
☐ Death rattle ☐ Apnea periods -sec. ○ Regular ○ Irregular
○ Regular ○ Irregular ○ Accessory muscles used

**DIAGNOSIS:**

Primary & Other Diagnosis 12 — ICD-10-CM 12

( _____ ) Date ____/____/____
( _____ ) Date ____/____/____
( _____ ) Date ____/____/____
( _____ ) Date ____/____/____
( _____ ) Date ____/____/____
( _____ ) Date ____/____/____

Surgical Procedure 12 — ICD-10-CM 12

( _____ ) Date ____/____/____
( _____ ) Date ____/____/____



PATIENT NAME - Last, First, Middle Initial | Med. Record #

# COMPREHENSIVE ADULT SOC ASSESSMENT
WITH CMS 485 (POC) INFORMATION

**PROGNOSIS:** 20

○1- Poor ○2- Guarded ○3-Fair ○4 Good ○5-Excellent

## SYSTEM REVIEW

**VISION**
☐ Glasses ☐ Glaucoma ☐ Jaundice
☐ Contacts: R / L ☐ Blurred vision ☐ Ptosis
☐ Prosthesis: R / L ☐ Legally blind
☐ Infections
☐ Cataract surgery: **Site** **Date** _____/_____/_____
☐ Other (specify, incl. hx)
☐ **NO PROBLEM**

**EARS**
☐ HOH: R / L ☐ Deaf: R / L ☐ Hearing aid: R/L
☐ Vertigo ☐ Tinnitus
☐ Other (specify, incl. hx)
☐ **NO PROBLEM**

## HEAD/NECK

☐ Headache(☐see Neurological section)
☐ Injuries/Wounds (☐see Skin Condition/Wound section)
☐ Masses/Nodes: **Site** **Size**
☐ Alopecia
☐ Other (specify, incl. hx)
☐ **NO PROBLEM**

## NOSE/THROAT/MOUTH

**NOSE**
☐ Congestion ☐ Epistaxis
☐ Loss of smell ☐ Sinus prob.
☐ Nose surgery:
☐ Other (specify, incl. hx)
☐ **NO PROBLEM**

**THROAT**
☐ Dysphagia ☐ Hoarseness
☐ Lesions ☐ Sore throat
☐ Other (specify, incl. hx)
☐ **NO PROBLEM**

**MOUTH**
☐ Dentures: Upper /Lower /Partial ☐ Masses/Tumors
☐ Gingivitis ☐ Ulcerations ☐ Toothache
☐ Any mouth surgery/procedure:
☐ Other (specify, incl. hx) ☐ **NO PROBLEM**

## ENDOCRINE

☐ Enlarged thyroid ☐ Fatigue ☐ Intolerance to heat/cold
☐ Diabetes: Type I/Type II Onset _____/_____/_____
☐ Diet/Oral control X ☐mos. ☐years
☐ Med./dose/freq.
☐ Insulin/dose/freq.
☐ Hyperglycemia: Glycosuria / Polyuria / Polydipsia
☐ Hypoglycemia: Sweats/Polyphagia/Weak/Faint/Stupor
☐ Blood Sugar Range
☐ Self-care/Self-observational tasks (specify)
☐ Other (specify, incl. hx)
☐ NO PROBLEM

## CARDIOVASCULAR STATUS

☐ Chest pain: ☐ Anginal ☐ Postural ☐ Localized ☐ Substernal
☐ Radiating ☐ Vise-like ☐ Sharp ☐ Dull ☐ Ache
Associated with: ☐ SOB ☐ Activity ☐ Sweats
Frequency/duration
Other (specify)
☐ Palpitations: Nocturnal/Persistent/intermittent
Other (specify)
**Heart rate:** ☐ Regular ☐ Irregular ☐ Reg./Irreg.
☐ Orthostatic hypotension ☐ Syncope ☐ Vertigo
☐ BP↑ (specify)
**Heart sounds:** ☐ Reg. ☐ Irreg. (specify)
☐ Pulse deficit (specify)
☐ Edema: ☐ Pedal R/L ☐ Dependent:
☐ Pitting +1/+2/+3/+4 ☐ Non-pitting (site)
☐ Claudication: R calf/L calf/Night changes
☐ JVD ☐ Fatigue
☐ Thrombus: Site Rx
☐ Cramps: LE/UE/Night (site)
☐ Cyanosis (site)
☐ Cap refill: <3 sec./ >3 sec.
☐ Pulses: LDP/LPT/RDP/RPT
☐ Pacemaker: Date _____/_____/_____ Type
☐ Other (specify incl. hx)
☐ **NO PROBLEM**

## RESPIRATORY STATUS

**Breath sounds:** ○Clear ○Crackles ○Wheeze ○Absent
☐ Cough: Dry/Acute/Chronic
☐ Productive: Thick/Thin/Difficult Color
☐ Smoker: packs/day X years
☐ Dyspnea: ☐ Rest ☐ Exertion: amb. feet
during ADLs
☐ Orthopnea: # of pillows
☐ Crepitus/☐ Fremitus: Location
☐ Hemoptysis: Frequency Amt.
☐ Barrel chest ☐ Skin temp/color change ☐ Percussion: Resonant/Tympanic/Dull
☐ Chart lobe: ○R ○L; ○Lat. ○Ant. ○Post.
☐ $0_2$ Sat.
☐ $0_2$ use: L/rnin. by ○Mask ○Nasal ○Trach
○Gas ○Liquid ○Concentrator
☐ Oxygen Precaution/Fire Prevention followed/explained to patient SG
☐ Other (specify, incl. hx)
☐ NO PROBLEM

## FUNCTIONAL LIMITATIONS 18A

☐ 1 -Amputation ☐ 4-Hearing ☐ 7-Ambulation ☐ A -Dyspnea with
☐ 2-Bowel/Bladder (incontinence) ☐ 5-Paralysis ☐ 8-Speech
☐ 3 - Contracture ☐ 6-Endurance ☐ 9-Legally blind
☐ B- Other (specify)

☐ Generalized Weakness ☐ Productive cough ☐ Legs weak
☐ Arthralgia ☐ Heartburn ☐ Back Pain
☐ Dizziness ☐ Pain on ambulation ☐ Decreased Bil. breath sounds
☐ Headache ☐ Unsteady Gait ☐ Palpitations
☐ Insomnia ☐ Varicositis on lower ext. ☐ Limited Mobility
☐ Anxiety ☐ Edema in ☐ Limited ROM
☐ SOB on exertion ☐ Chest pain on exertion ☐ Leg cramps
☐ Poor vision ☐ Fatigues at times ☐ Freq. Coughing episodes
☐ Needs assistance of 1 person

## HOMEBOUND REASON: 18A

*(Mark all that apply):*
☐ **Needs assist of 1-2 persons**
☐ Needs assistance for all activities (ADL's)
☐ Generalized Weakness
☐ Medical restrictions
☐ Unsteady Gait
☐ Dependent upon adaptive device(s)
☐ Requires assistance to ambulate/Decreased Range of Motion
☐ Confusion, unable to go out of home alone
☐ Unable to safely leave home without assistance
☐ Mobility/Ambulatory device(s) used:
☐ Severe SOB, SOB upon exertion, amb. ____ feet
☐ Bedbound (Partial/Complete)
☐ Other (specify):

## GENITOURINARY STATUS

**(Check all that apply:)** ☐ Burning/pain ☐ Hesitancy ☐ Hematuria ☐ Oliguria/anuria ☐ Urgency/frequency ☐ Nocturia x
☐ **Incontinence:** ☐ Urinary ☐ Bowel ☐ Diapers/other:
Color: ○Yellow/straw ○Amber ○Brown/gray ○Blood-tinged ○Other: **Clarity:** ○Clear ○Cloudy ○Sediment/mucous
**Odor:** ○Yes ○No ☐ **Urinary Catheter:** Type Last changed on: Foley inserted (date) with French
Inflated balloon with mL ☐ without difficulty ☐ Suprapubic Irrigation solution: Type (specify): Amount mL Frequency Returns
Patient tolerated procedure well ○Yes ○No ☐ Urostomy (describe skin around stoma):

PATIENT/CLIENT NAME - Last, First, Middle Initial | Med. Record #

## NUTRITIONAL STATUS

**16 DIET, Nutritional requirements:** ☐Controlled Carbohydrate

☐2 gm Sodium ☐Low Sodium ☐NAS ☐NPO ☐1800 cal ADA

☐Low Fat ☐Low cholesterol Other: _____

☐Increase fluids:_____amt. ☐Restrict fluids_____amt.

**Appetite:** ☐Excellent ☐Good ☐Fair ☐Poor ☐Anorexic

☐Nausea ☐Vomiting: Frequency:_____

Amount: _____

☐**Heartburn** (food intolerance): Frequency: _____

☐Other:_____

## NUTRITION HEALTH SCREEN

**Directions:** Circle each area with "yes" to assessment, then total score to determine additional risk.

| | YES |
|---|---|
| Has an illness or condition that changed the kind and/or amount of food eaten. | 2 |
| Eats fewer than 2 meals per day. | 3 |
| Eats few fruits, vegetables or milk products. | 2 |
| Has 3 or more drinks of beer, liquor or wine almost every day. | 2 |
| Has tooth or mouth problems that make it hard to eat. | 2 |
| Does not always have enough money to buy the food needed. | 4 |
| Eats alone most of the time. | 1 |
| Takes 3 or more different prescribed or over-the-counter drugs a day. | 1 |
| Without wanting to, has lost or gained 1 0 pounds in the last 6 months. | 2 |
| Not always physically able to shop, cook and/or feed self. | 2 |
| TOTAL | |

**INTERPRETATION**

0-2 Good. As appropriate reassess and/or provide information based on situation.

3-5 Moderate risk. Educate, refer, monitor and reevaluate based on patient situation and organization policy.

6 or > High risk. Coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care.

☐**NO PROBLEM**



## ELIMINATION STATUS

**Last BM** _____/_____/_____ **Usual frequency**_____

☐Diarrhea: Black / watery / Sanguineous ☐<3x/day ☐>3x/day

Mucus/Pain/Foul odor/Frothy Amount _____

☐Abnormal stools: Gray/Tarry/Fresh blood

☐Constipation: Chronic/Acute/Occasional

☐Lax./Enema use: Type _____ Freq._____

☐Hemorrhoids: Internal/External/Painful

☐Rx (specify) _____

☐Flatulence: Freq. _____

☐Impaction ☐Incontinence of stool: Freq. _____

☐Abdominal distention: Cramping/Pain Freq._____

☐Ascites: Girth_____ inches

Firm/Tender X_____ quads

**Bowel sounds:** Active/Hyperactive X_____ quads

☐Absent X_____ quads

Rebound/Hot/Red/Discolored

☐Colostomy: Sigmoid/Transverse Date _____/_____/_____

☐**NO PROBLEM**

## PSYCHOSOCIAL

**Primary language:** ☐English ☐Spanish ☐Creole ☐Russian _____

☐Language barrier ☐Needs interpreter _____

☐Learning barrier: Mental/Psychosocial/Physical/Functional

☐Able to read/write Educational level _____

☐Spiritual/Cultural implications that impact care.

Spiritual resource_____ Phone No._____

☐Angry ☐Flat affect ☐Discouraged ☐Suicidal: Ideation /Verbalized

☐Withdrawn ☐Difficulty coping ☐Disorganized

☐Substance use: Drugs/Alcohol/Tobacco

Plan_____

## ACTIVITIES PERMITTED

☐1 -Complete bedrest ☐8-Crutches CMS 485 (POC): **18B**

☐2-Bedrest/BRP ☐9-Cane

☐3-Up as tolerated ☐A-Wheelchair

☐4-Transfer bed/chair ☐B-Walker

☐5-Exercises prescribed ☐C-No restrictions

☐6-Partial weight bearing ☐D-Other (specify) _____

☐7-Independent in home _____

### LIVING ARRANGEMENTS/CAREGIVER INFORMATION

☐House ☐Apartment ☐New environment

☐Family present ☐Lives alone ☐Lives w/others:_____

**Primary caregiver** (name) _____

Relationship/Health status _____

☐Assists with ADLs ☐Provides physical care

☐Other (specify)_____

☐Secondary/Other caregivers (describe) _____

## GENITALIA

☐Discharge/Drainage: Urine/Vag. mucus/Feces ☐Surgical alteration

☐Lesions/Blisters/Masses/Cysts ☐Inflammation

☐Prostate problem: BPH/TURP Date _____/_____/_____

☐Self-testicular exam Freq._____

☐Menopause: ☐Hysterectomy Date _____/_____/_____

Date last PAP _____/_____/_____ Results_____

☐Breast self-exam. freq._____ ☐Discharge: R/L

☐Mastectomy: R/L Date _____/_____/_____

☐Other (specify incl. hx)_____

_____ ☐**NO PROBLEM**

## HEMATOLOGY/ IMMUNE

☐Anemia: Iron deficient/Pernicious ☐Secondary Bleed: GI/GU/GYN/Unknown

☐Thrombocytopenia ☐Coagulation disorders Ablastic/Hemolytic/Polycythemias

☐Hemophilia, other_____

☐Malignancies (specify): _____

Prior Rx_____

Complications _____

☐Other (specify, immunological problem)_____

_____ ☐**NO PROBLEM**

## NEUROLOGICAL

☐Slurred speech ☐Oriented X_____

☐Syncope ☐Insomnia/Change in sleep pattern

☐Sensory loss ☐Vertigo

☐Numbness ☐Ataxia

☐Impaired decision-making ability ☐Hx of frequent falls

☐Memory loss: Short term/Long term

☐Headache: Loc._____ Freq._____

☐Aphasia: Receptive/Expressive ☐Motor change: Fine/Gross

☐Weakness: UE/LE Location_____

☐Tremors: Fine/Gross/Paralysis

☐Stuporous/Hallucinations: Visual/Auditory

☐Unequal pupils: R/UPERRLA

**Hand grips:** Equal/Unequal, specify _____

Strong/Weak, specify_____

☐Psychotropic drug use (specify) _____

Dose/Freq. _____

☐Other (specify, incl. hx) _____

_____ ☐**NO PROBLEM**

☐Depressed: Recent/Long term Fix _____

Due to: ☐Lack of motivation ☐Inability to recognize problems

☐Unrealistic expectations ☐Denial of problems ☐Other, specify _____

☐Inappropriate responses to caregivers/clinician ☐Invested in "sick role"

☐Inappropriate follow-through in past

☐Evidence of abuse: ☐Potential ☐Actual ☐Verbal/Emotional ☐Financial ☐Physical

**MENTAL STATUS: 19**

☐1 - Oriented ☐3 - Forgetful ☐5 - Disoriented ☐7 - Agitated

☐2 - Comatose ☐4 - Depressed ☐6 - Lethargic

☐8 - Other: _____

☐Forgetful at times ☐Irritable ☐Anxious ☐Alert ☐**NO PROBLEM**

PATIENT/CLIENT NAME - Last, First, Middle Initial | ID#

## SAFETY MEASURES

**Safety Measures: CMS485 (POC)** 15

- ☐ Cast Precautions
- ☐ Change position slowly
- ☐ Coumadin/Heparin Precautions
- ☐ Do not lift, bend, stoop
- ☐ Good handwashing technique
- ☐ Oxygen Precaution/Fire prevention SG
- ☐ Practice Universal Precautions
- ☐ 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
- ☐ Other: _____
- ☐ Oxygen: HME Co. _____
- Phone: _____
- ☐ Fire Alarm ☐ Smoke Alarm

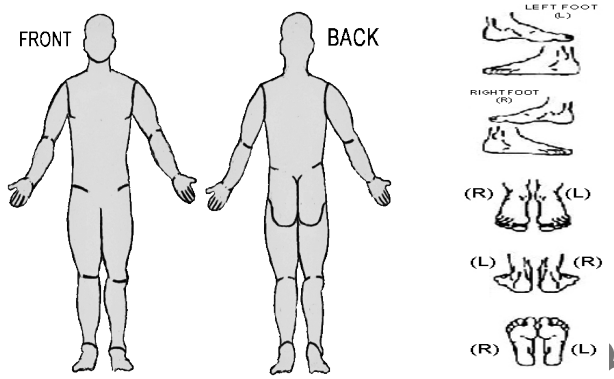
## SKIN CONDITION/WOUNDS/LESION

☐ Itch ☐ Rash ☐ Dry ☐ Scaling ☐ Incision ☐ Wounds ☐ Lesions
☐ Decubitus ☐ Fistulas ☐ Abrasions ☐ Lacerations ☐ Sutures ☐ Staples

☐ Bruises ☐ Ecchymosis ☐ Pallor: ☐ Jaundice ☐ Redness
Turgor: ◯ Good ◯ Poor Edema: ☐ Lymph ☐ Hema. ☐ **NO PROBLEM**

Other (specify, incl. pertinent hx) _____

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below.




| CONDITION | #1 | #2 | #3 | #4 |
|---|---|---|---|---|
| Size (cm) | | | | |
| Depth / **Stage** | | | | |
| Drainage/Amt. | | | | |
| Tunneling | | | | |
| Odor / **Sur. Tis.** | | | | |
| Edema / Stoma | | | | |

## ALLERGIES

☐ None known / NKA ☐ Aspirin ☐ Eggs ☐ Insect bites 17
☐ Penicillin ☐ Sulfa ☐ Animal dander and urine ☐ Dairy/Milk products
☐ Iodine ☐ Pollens and mold spores ☐ Dust mites
☐ Other _____

## MUSCULOSKELETAL

☐ Fracture (location) _____
☐ Swollen, painful joints (specify) _____
☐ Contractures: Joint _____ Location _____
☐ Atrophy ☐ Poor conditioning
☐ Decreased ROM _____ ☐ Paresthesia _____
☐ Shuffling/Wide-based gait ☐ Weakness
☐ Amputation: BK/AK/UE; R/L (specify) _____
☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia
☐ Other (specify, incl. pertinent hx) _____

**APPLIANCES/AIDS/SPECIAL EQUIPMENT:** ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutch(es) ☐ Lifts ☐ Bedside Commode ☐ Prosthesis: _____
☐ Other (specify): _____ ☐ Hospital bed

## PAIN MANAGEMENT

Location _____ Origin: _____
Onset _____
Present Pain Management Regimen _____
Effectiveness _____
Other (specify) _____
Quality (i.e., burning, dull ache) _____
**Intensity level: 0 1 2 3 4 5 6 7 8 9 10**
Freq./Duration _____
Aggravating/Relieving Factors: _____
Pain Management History _____
Patient is prone to FALL: ◯ No ◯ Yes: _____
☐ Fall risk assessment conducted every _____ ☐ **NO PROBLEM**
☐ Fall prevention program in place, patient instructed SG
Comment: _____

## 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 |
| | 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 |
| | Medications stored safely, clearly-easy use | ◯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 |
| | 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 |

## ENTERAL FEEDINGS - ACCESS DEVICE - IV

☐ TPN ☐ Nasogastric ☐ Gastrostomy ☐ Jejunostomy ☐ Feeding type: _____
**Device:** ☐ IV: _____ _____
☐ Pump: (type/specify) _____ ☐ Bolus ☐ Continuous
**Financial ability to pay for medications/insurance covered:** ◯ Yes ◯ No
Comment: _____ ☐ **N/A**

PATIENT/CLIENT NAME - Last, First, Middle Initial

Med. Record #

## PATIENT CARE COORDINATION

**CARE PLAN:** ☐ Reviewed with patient involvement **CARE COORDINATION:** ☐ Physician ☐ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ Aide ☐ Other (specify):

**MEDICATION RECORD:** ☐ Medication Form completed/reviewed/updated (10) ☐ No change ☐ Order obtained _____

(SG) **Medication Management**, Check all that applies/identified: ☐ Potential adverse effects/drug reactions ☐ Ineffective drug therapy ☐ Significant side effects ☐ Significant drug interactions ☐ Non-compliance with drug orders ☐ Duplicate drug therapy

Explain: _____

☐ Expected Outcome: _____

☐ Patient unable to perform own Wound Care due to _____

☐ Patient unable to Insuline/Injection self administration due to _____

☐ No S/O or C/G able/willing for wound care/Insulin-Injection administration at this time: _____

## DME SUPPLIES

(14)

- ☐ Saline/NSS
- ☐ 2x2's
- ☐ 4x4's
- ☐ ABD's
- ☐ Telfa
- ☐ Tape
- ☐ Cotton tipped applicators
- ☐ Wound cleanser
- ☐ Wound gel
- ☐ Drain sponges
- ☐ Gloves: ☐ Sterile ☐ Non-sterile
- ☐ Hydrocolloids
- ☐ Kerlix size _____
- ☐ Nu-gauze
- ☐ Transparent dressings
- ☐ Ointment

_____

- ☐ Colostomy Supplies
- ☐ Thermometer
- ☐ Red Box (Biohazard)
- ☐ Sharp Container

- ☐ Injection caps
- ☐ IV start kit
- ☐ IV pole
- ☐ IV tubing
- ☐ Alcohol swabs
- ☐ Angiocatheter size _____

_____

- ☐ Peroxide
- ☐ Extension tubings
- ☐ Central line dressing
- ☐ Infusion pump
- ☐ Batteries size _____

_____

- ☐ Syringes size _____

_____

- ☐ Duoderm
- ☐ Betadine Solution
- ☐ Ace band size
- ☐ MEFIX 2X11 YD (EA)
- ☐ MICROPORE TAPE 2"
- ☐ SOFTWICK 4X4

- ☐ Abd Pads
- ☐ Underpads, size:

_____

- ☐ External catheters
- ☐ Urinary bag/pouch
- ☐ Ostomy pouch (brand, size)

_____

- ☐ Ostomy wafer (brand, size)

_____

- ☐ Stoma adhesive tape
- ☐ Skin protectant

_____

**FOLEY/CATH SUPPLIES:**

- ☐ _____ Fr catheter kit (tray, bag, foley)
- ☐ Leg Straps Cath
- ☐ Straight catheter
- ☐ Irrigation tray
- ☐ Saline/NSS ☐ Texas Cath
- ☐ Acetic acid
- ☐ Other _____

_____

_____

_____

- ☐ ALCOHOL PREP PADS
- ☐ Chemstrips
- ☐ Syringes
- ☐ COTTON TIP APP
- ☐ DUODERM CFG
- ☐ HY-TAPE 2"
- ☐ INSERTION TRAY 5CC
- ☐ INSULIN SYRINGE ___ CC
- ☐ SYRINGES

_____

- ☐ Glucometer

_____

- ☐ Enema supplies
- ☐ Feeding tube: type_____ size_____
- ☐ Suture removal kit
- ☐ Staple removal kit
- ☐ Steri strips
- ☐ TRIPLE ANTIBIOTIC 30GR
- ☐ VASELINE GAUZE 3X9
- ☐ KLING 4

_____

- ☐ Side Rails
- ☐ Bathbench
- ☐ Cane ☐ Quad Cane
- ☐ Commode
- ☐ Special mattress overlay

_____

- ☐ Pressure relieving device

_____

- ☐ Eggcrate
- ☐ Hospital bed
- ☐ Hoyer lift
- ☐ Enteral feeding pump
- ☐ Nebulizer
- ☐ Oxygen concentrator

_____

- ☐ Suction machine
- ☐ Ventilator
- ☐ Walker
- ☐ Wheelchair
- ☐ Tens unit
- ☐ Other _____

_____

_____

_____

## PATIENT OTHER EVALUATIONS

**Check all that applies:**

Patient/caregiver(CG) independent with:

| | | | |
|---|---|---|---|
| Wound/Decubitus care: | ◯ Yes | ◯ No | ◯ N/A |
| Diabetic management/care: | ◯ Yes | ◯ No | ◯ N/A |
| Insulin administration: | ◯ Yes | ◯ No | ◯ N/A |
| Glucometer use/calibration: | ◯ Yes | ◯ No | ◯ N/A |
| Nutritional management/Diet: | ◯ Yes | ◯ No | ◯ N/A |
| Trach care: | ◯ Yes | ◯ No | ◯ N/A |
| Ostomy care: | ◯ Yes | ◯ No | ◯ N/A |
| Foley care: | ◯ Yes | ◯ No | ◯ N/A |

Medication management: Administration: ☐ Oral ☐ Injection ☐ IV-Infused ☐ Inhaled

| | | | |
|---|---|---|---|
| Physician follow up visits/appointments maintained: | ◯ Yes | ◯ No | ◯ N/A |
| Oxygen use/precautions maintained, fire prevention: (SG) | ◯ Yes | ◯ No | ◯ N/A |
| Use of home medical equipment / devices: | ◯ Yes | ◯ No | ◯ N/A |
| Pain Management / Home prescribed exercises: | ◯ Yes | ◯ No | ◯ N/A |
| Elimination, Incontinence management: _____ | ◯ Yes | ◯ No | ◯ N/A |

Does the patient/CG have a plan when disease symptoms exacerbate (e.g., when to call the nurse / Agency vs. emergency **911**): ◯ Yes ◯ No

☐ Pshycological care / behaviour problems prevention

Caregiver/Family member present during the visit: ◯ Yes ◯ No ◯ N/A

Patient/CG able to understand instructions/teaching: ◯ Yes ◯ No Explain: _____ ☐ NEEDS FURTHER TEACHING

Comment(s): _____



## (21) Orders by discipline (optional) To complete CMS485 (POC)

**SN - ORDERS - FREQUENCY/DURATION:** _____ _____

☐ SKILLED OBSERVATION/EVALUATION ASSESS VITAL SINGS & S/S COMPLICATIONS: _____ _____

General ☐ INSTRUCT/EVALUATE UNDERSTANDING OF DISEASE PROCESS ☐ DETECTING COMPLICATIONS ☐ DIET/NUTRITIONAL STATUS ☐ SAFETY PRECAUTION/EMERGENCY MEASURES, MED-REGIMEN _____ _____

_____ _____

**PT - ORDERS - FREQUENCY/DURATION:** _____ _____

**OT - ORDERS - FREQUENCY/DURATION:** _____ _____

**ST - ORDERS - FREQUENCY/DURATION:** _____ _____

**OTHER - ORDERS - FREQUENCY/DURATION:** _____ _____

| PATIENT/CLIENT NAME - Last, First, Middle Initial | Med. Record # |
|---|---|
| | |

**If the patient experiment:**
-ADL/IADL Deficit - Elimination Deficit - Impaired Mobility:
**Indications for Home Health Aide may be needed:**

MD Order obtained: ◯ Yes ◯ No Patient/Family: ☐ Refused

☐ N/A (Home Health Aide Services not needed)

Other Services ordered: ☐ SN ☐ MSW ☐ PT ☐ OT ☐ ST

☐ Comment: _____

21

## AIDE - ORDERS - FREQUENCY/DURATION: _____

☐ TUB/SHOWER BATH ☐ WASH CLOTHES
☐ PERSONAL CARE ☐ LIGHT HOUSEKEEPING
☐ HAIR COMB ☐ ASSIST TO DRESS
☐ ORAL HYGIENE ☐ PERI CARE
☐ TPR _____ ☐ ASSIST WITH PERSONAL CARE AND ADL'S
☐ REPORT SIGNIFICANT FINDING TO AGENCY/CASE MANAGER
☐ OTHER: _____

## ACTIVITIES OF DAILY LIVING (Legend: I-Independent; A-Assist; D-Dependent)

| ACTIVITY | PRIOR Level of Function | I | A | D | COMMENTS (who assists, assistive device used, etc.) |
|---|---|---|---|---|---|
| Eating/Kitchen access | | | | | |
| Transfer abilities | | | | | |
| Dressing/Grooming | | | | | |
| Bathing/ Personal Care | | | | | |
| Toileting/Hygiene abilities | | | | | |
| Ambulation/ROM | | | | | |
| Communication (verbal, non-verbal) | | | | | |
| Preparing/Serving light meals | | | | | |
| Preparing full meals | | | | | |
| Light housekeeping | | | | | |
| Personal laundry | | | | | |
| Handling money | | | | | |
| Using telephone | | | | | |
| Reading, Writing | | | | | |
| Hair care, Skin Care | | | | | |
| Managing Medications | | | | | |
| Other (Specify) | | | | | |

## GOALS 22

☐ RETURN TO INDEPENDENT AMBULATION. BE SAFE IN SELF CARE.
☐ PATIENT WILL BE ABLE TO FUNCTION WITH ASSISTANCE OF CAREGIVER WITHIN HIS/HER CURRENT LIMITATIONS AT HOME.
☐ GOOD/FAIR RETURN TO PREVIOUS LEVEL OF ADLS INDEPENDENTLY.
☐ PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATIONS AT HOME.
☐ OTHER: _____

## DISCHARGE PLANS

☐ WILL DISCHARGE THE PATIENT WITHIN ____ WEEKS, WHEN PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE PROPER CARE MANAGEMENT, NO S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
☐ OTHER: _____

Discussed with patient/client? ◯ Yes ◯ No REHAB POTENTIAL LEVEL: _____

**Instructions/Information Provided** (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, instructions
☐ Agency phone numbers, address ☐ Home safety guidelines
☐ Client Information Handbook ☐ Alzheimer's, Fall prevention, Sensory impairments info
☐ Pain Management info ☐ Grievance Procedures
☐ Standard precautions /handwashing/ Infection Control
☐ Admission criteria, Information for Home visit, Services, Frequency
☐ Diabetes Control, other disease management information
☐ Care Plans ☐ Local Resources Guide ☐ Mission, ownership information
☐ Other _____



## SKILLED INTERVENTION/SERVICE

☐ **Skilled Observation / Assessment** ☐ Foley Change/Care ☐ Patient Education/teaching ☐ Wound Care / Dressing Change ☐ Prep. / Admin. Insulin ☐ Diabetic Observation / Care
☐ INJECTION ROUTE:_____ SITE: _____ MED. GIVEN: _____ DOSE: _____ REACTION: _____ ☐ Procedure/Tx well tolerated by Pt.
☐ Standard/Universal Precautions Followed ☐ Aseptic Tech. Used. ☐ Quality Control of Glucometer Performed ☐ Sharps Discarded Inside Sharps Container
☐ Correct handwashing technique followed SG ☐ Management/Evaluation Patient's Care Plan ☐ No caregiver/family available/willing to help patient with care, procedures.

DRUG REGIMEN REVIEW COMPLETED/RECONCILIATED? ◯ Yes ◯ No
PATIENT/CLIENT/CAREGIVER RESPONSE _____

## SUMMARY CHECKLIST

☐ AIDE CARE PLAN COMPLETED, REVIEWED, EXPLAINED TO AIDE ☐ N/A
☐ Frequency of Supervision: _____ Authorization obtained from Patient/CG ☐ N/A
If needed, Branden, Flac, Timed Get Up scale/test were completed? ◯ Yes ◯ No
PATIENT ADMISSION PACKAGE COMPLETED, AGREEMENT EXPLAINED TO PATIENT? ◯ Yes ◯ No

## SIGNATURES/DATES

X _____ /____/____
*Patient\Client\Caregiver (optional if weekly is used)* *Date*

_____ /____/____
*Professional signature/title* *Date*

PATIENT/CLIENT NAME - Last, First, Middle Initial

*Med. Record #*

Patient Name: _____ Med. Record # _____

## Orders by discipline (optional) To complete CMS485 (POC)

**21** **Included as reference only, your Professional Staff must review/update/personalized/approve the orders.**

### SN - ORDERS - FREQUENCY/DURATION: _____

☐ SKILLED OBSERVATION/EVALUATION ASSESS VITAL SINGS & S/S COMPLICATIONS: _____

**General** ☐ INSTRUCT/EVALUATE UNDERSTANDING OF DISEASE PROCESS ☐ DETECTING COMPLICATIONS ☐ DIET/NUTRITIONAL STATUS ☐ SAFETY PRECAUTION/EMERGENCY MEASURES, MED-REGIMEN

**Angina** ☐ ASSESS FOR CHEST PAIN: TYPE, LOCATION, INTENSITY, DURATION & FREQUENCY ☐ I/S PAIN MANAGEMENT ☐ NOTIFY M.D. IF PAIN PERSISTS. I/S GRADUAL PROGRESS ACTIVITY INCREASE ☐ INST. DISCONTINUE ACTIVITY IF CHEST PAIN, DYSPNEA, FATIGUE OR PALPITATIONS OCCUR.

**Foley Care** ☐ FOLEY INSERTION _____FR. FOLEY WITH_____cc BALLON ☐ INST. S/S INFECTION ☐ CHANGE Q MONTH & PRN x3 FOR CLOGGED, LEAKING, OR ACCIDENTAL REMOVAL ☐ INST. DRESSING CHANGES _____. MONITOR FOR S/S COMPLICATIONS & NOTIFY M.D.

**Wound Care** ☐ MONITOR STATUS OF WOUND OR DECUBITUS (place) _____

**Decubitus** ☐ INST. INFECTION CONTROL MEASURES ☐ INST. GOOD NUTRITION TO FACILITATE HEALING ☐ REPORT ANY ELEVATIONS IN TEMPERATURE TO THE M.D. ☐ MEASURE AND RECORD WOUND or DECUBITUS SIZE AT SOC AND AT LEAST WEEKLY THEREAFTER ☐ OPEN WOUND CARE/DRESSING: CLEANSE WOUND WITH _____, TO RINSE WITH _____ AND APPLY_____ AND PRN ☐ DECUBITUS CARE/DRESSING: CLEANSE WOUND WITH _____, TO RINSE WITH _____ AND APPLY_____ AND PRN ☐ OBSERVE AND RECORD TYPE AND AMOUNT OF DRAINAGE, COLOR, INFECTION: SWELLING, REDNESS, PAIN

**Asthma/Respiratory** ☐ TEACH THE PATIENT HOW TO USE A METERED-DOSE INHALER ☐ MAINTAIN EFFECTIVE AIRWAY CLEARANCE ☐ INST. DISEASE PROCESS & MAINTENANCE ☐ PROMOTE AN EFFICIENT BREATHING PATTER ☐ IMPROVE THE PT'S ABILITY TO PREVENT OR COPE WITH BREATHING DIFFICULTIES. ☐ INST. INFECTION CONTROL & PULMONARY HYGIENE ☐ INST. COMPLICATIONS IN CARDIOPULMONARY STATUS ☐ INST. PREVENTION OF COMPLICATIONS: IE: AVOID OVER-EXERTION, CHILLING, CROWDS, ETC. ☐ INSTRUCT COUGHING, DEEP BREATHING EXERCISES. ☐ INST. PATIENT TO MAINTAIN ADEQUATE REST PATTERN. ☐ INST. PACED ACTIVITY PROGRAM. ☐ EMPHASIZE THE IMPORTANCE OF ADEQUATE DAILY FLUID INTAKE

**Oxygen** ☐ INSTRUCT PROPER ADMINISTRATION OF OXYGEN THERAPY. INSTRUCT OXYGEN PRECAUTIONS. ☐ INSTRUCT MAINTENANCE OXYGEN EQUIPMENT.

**CHF** ☐ OBSERVE FOR S/S OF DECOMPENSATION SUCH AS INCREASING TACHYCARDIA, W/SUDDEN ONSET, SOB ON MIN. EXERTION, ORTHOPNEA, EXTREME ANXIETY, PROGRESSIVE CYANOSIS, GENERALIZED PALLOR AND DIAPHORESIS.

**Genera** ☐ MANAGEMENT AND EVALUATION OF A PATIENT CARE PLAN ☐ **TEACHING AND TRAINING**: DISEASE PROCESS ☐ SKIN CARE, WOUND CARE/DRESSING CHANGE, DECUBITUS CARE ☐ MEDICATION REGIMEN ☐ DIET/NUTRITION/HYDRATION ☐ COMPLICATIONS OF ENT. FEEDING AS INDICATED ☐ PAIN CONTROL MEASURES, SYMPTOM CONTROL MEASURES ☐ SINGS/SYMPTOMS OF INFECTION, ☐ SAFETY/PREVENTION OF INJURY ☐ EMERGENCY PLANS ☐ OXYGEN ADMINISTRATION

**Insulin** ☐ INSTRUCT IN PREPARATION & ADMINISTRATION OF INSULIN ☐ INSTRUCT ONSET, PEAK & DURATION OF ACTION OF INSULIN ☐ INSTRUCT PROPER DISPOSAL OF SYRINGES/NEEDLES

**Glucometer** ☐ NURSE TO MONITOR BLOOD SUGAR WITH GLUCOMETER OR _____ON _____FREQUENCY, & NOTIFY M.D. OF ALTERED RESULTS ☐ TEACH GLUCOMETER OR _____ PROCEDURE & INTERPRETING RESULTS

**Diabetes Mellitus** ☐ INST. DISEASE PROCESS & COMMON COMPLICATIONS ☐ INST. PRESCRIBED DIET & SHOPPING ADVICE. INST. S/S HYPO/HYPERGLYCEMIA & EMERGENCY PROCEDURES ☐ INST. GOOD SKIN CARE & GOOD FOOT CARE, DAILY CARE OF TEETH. INST. DIABETIC CHART. INST. S&A TESTING & READING RESULTS ☐ INSTRUCT TO CARRY I.D. THAT INCLUDES INFORMATION REGARDING DIABETIC STATUS, NAMES & DOSAGE OF MEDS & ACTION TO TAKE IF INSULIN REACTION OCCURS ☐ INST. IMPORTANCE OF GOOD PERSONAL HEALTH HABITS, INCLUDING EXERCISE, ADEQUATE REST, SLEEP, REGULAR MED CHECK-UPS (INCLUDING PODIATRIC, OPTHAMOLOGIST & DENTIST).

**Anemia** ☐ INST. FOR S/S: EASY FATIGABILITY, DYSPNEA, PALPITATIONS, ANGINA TACHYCARDIA, PALLOR, DIZZINESS, JAUNDICE AND FEVER. ☐ INST. FOR G.I. DISTURBANCES. ASSESS FOR CENTRAL NERVOUS SYSTEM SYMPTOMATOLOGY ☐ OBTAIN APPROPRIATE LAB TESTS AND REPORT FINDINGS TO M.D. ☐ ADMINISTER PRESCRIBED INJECTABLE _____ USING _____ TECHNIQUE

**Depression** ☐ ASSESS PSYCHOLOGICAL STATUS ☐ PROVIDE SUPPORTIVE THERAPY, PROVIDE REMOTIVATION ☐ ASSESS INTERPERSONAL BEHAVIOR ☐ ASSIST PATIENT TO DEFINE PROBLEMS & SOCIAL RELATIONSHIPS. GIVE POSITIVE REINFORCEMENT ☐ ENCOURAGE PATIENT TO PERFORM PERSONAL HYGIENE & GROOMING ACTIVITIES ☐ ASSIST PATIENT TO EXPRESS REALISTIC IDEAS & PLANS. ASSIST PATIENT TO VERBALIZE FEELINGS.

**Anxiety** ☐ PROVIDE SUPPORTIVE AND RELAXATION THERAPY ☐ PROVIDE FAMILY THERAPY. ASSESS INTERPERSONAL BEHAVIOR ☐ ASSIST PATIENT TO DEFINE PROBLEMS & SOCIAL RELATIONSHIPS. GIVE POSITIVE REINFORCEMENT. ☐ ASSIST PATIENT TO VERBALIZE FEELINGS.

**Alzheimer's** ☐ PSYCHOLOGICAL ASSESSMENT ☐ ASSESS NEUROLOGICAL STATUS ☐ IMPLEMENT AND MONITOR BOWEL REGIMEN & TEACH PROGRAM TO FAMILY ☐ SN TO MONITOR TRANQUILIZER EFFECTS GIVEN FOR SEVERE AGITATION/ANXIETY. ☐ EVALUATE FOR WEIGHT LOSS, WEIGH PATIENT Q VISIT, AND RECORDS WEIGHTS ☐ MONITOR LEVEL OF CONSCIOUSNESS ☐ ASSESS COORDINATION AND BALANCE. PROVIDE EMOTIONAL SUPPORT TO PATIENT AND FAMILY ☐ OBSERVATION AND EVALUATION OF BLADDER ELIMINATION HABITS, MANAGEMENT IF INCONTINENCE. ☐ ASSIST FAMILY IN SETTING UP ROUTINE PATIENT-CENTERED AND STRESS THE IMPORTANCE OF ADHERING.

**Psychiatric** ☐ PSYCH ASSESSMENT: ASSESS FOR S/S OF EPS ☐ RELAXATION TECHNIQUES ☐ DETECT AND ALLEVIATE SOMATIZED COMPLAINTS ☐ GOAL ORIENTED TASKS ☐ LIMIT SETTING MOTIVATION TECHNIQUES, IMAGERY TECHNIQUES ☐ OTHER: _____

**Hypertension** ☐ INST. DISEASE PROCESS AND COMMON COMPLICATIONS ☐ INST. LOW SODIUM DIET - STRESSING IMPORTANCE OF ADHERENCE ☐ MONITOR PATIENT'S BLOOD PRESSURE CLOSELY AND NOTIFY M.D OF ANY SIGNIFICANT CHANGES. ☐ INSTRUCT PT. TO AVOID OVER-THE-COUNTER COLD AND SINUS MEDS AS THEY CONTAIN VASOCONSTRICTOR ☐ INST. OF HYPERTENSIVE CRISIS ☐ MONITOR FOR S/S OF ORTHOSTATIC HYPOTENSION.

**Osteoarthritis** ☐ INSTRUCT PATIENT IN CONSEQUENT PHYSICAL LIMITATIONS, PLANNING AN ADEQUATE LEVEL OF DAILY ACTIVITIES ☐ TEACH PT R/E ARTHRITIS S/S OF EXACERBATION. TEACH THE IMPORTANCE OF GOOD POSTURE, PREVENT TRAUMA TO JOINTS ☐ INST. PT IN THE USE OF ASSISTIVE DEVICE AS PRESCRIBED.

### AIDE - ORDERS - FREQUENCY/DURATION: _____

☐ TUB/SHOWER BATH ☐ PERSONAL CARE ☐ HAIR COMB ☐ SHAMPOO PRN ☐ MOUTH/DENTURE CARE ☐ SKIN CHECK ☐ ORAL HYGIENE ☐ TPR
☐ ASSIST TO DRESS ☐ ASSIST WITH AMBULATION ☐ PREPARE SERVE MEALS ☐ GROCERY SHOP ☐ WASH CLOTHES ☐ LIGHT HOUSEKEEPING ☐ ASSIST WITH PERSONAL CARE AND ADL'S
☐ ERRANDS ☐ NOTIFY LAST BM IF NONE FOR 3 DAYS ☐ FEET/NAILS CARE ☐ PERI CARE ☐ REPORT SIGNIFICANT FINDING TO SN ☐ STRAIGHTEN ROOM & CHANGE LINEN

### PT - ORDERS - FREQUENCY/DURATION: _____

☐ EVALUATE BALANCE AND COORDINATION ☐ EVALUATE ENDURANCE, MOBILITY ☐ NEUROMUSCULAR RE-EDUCATION,
☐ PERFORM PRESCRIBED THERAPEUTIC EXERCISES ☐ NOTIFY SIGNIFICANT FINDING TO MD/AGENCY ☐ BED MOBILITY TRAINING
☐ GAIT TRAINING WITH ASSISTIVE DEVICE ☐ TEACH HOME MAINTENANCE PROGRAM AND STRENGTHENING EXERCISE
☐ EXERCISE BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN ☐ TRANSFER TRAINING ☐ INSTRUCT IN SAFETY MEASURES, FALL PRECAUTIONS

### OT - ORDERS - FREQUENCY/DURATION: _____

☐ EVALUATE PATIENT AND HOME FOR SAFETY ☐ ADL TRAINING PROGRAM ☐ MUSCLE RE-EDUCATION, BODY IMAGE TRAINING
☐ INCREASE RIGHT AND LEFT UPPER EXTREMITIES STRENGTH ☐ THERAPEUTIC EXERCISE TO (R) AND (L) HAND
☐ INCREASE STRENGTH AND COORDINATION ☐ PROPRIOCEPTION AND SENSATION.

### ST - ORDERS - FREQUENCY/DURATION: _____

☐ ST FOR EVALUATION ☐ TO PROVIDE ORAL MOTOR EXERCISES INVOLVING LINGUAL AND LABIAL EXERCISES ☐ SPEECH ARTICULATION DISORDER TREATMENT
☐ IMPROVE SPEECH ☐ FACIAL SYMMETRY AND MUSCULATION ☐ IMPROVE DYSPHAGIA ☐ VOICE DISORDER TREATMENT
☐ AURAL REHABILITATION ☐ NON-ORAL COMMUNICATION ☐ LANGUAGE DISORDER TREATMENT

### MSW - ORDERS - FREQUENCY/DURATION: _____

☐ MSW FOR ASSESSMENT OF SOCIAL AND EMOTIONAL FACTORS ☐ COMMUNITY RESOURCE PLANNING
☐ COUNSELING REGARDING MANAGEMENT/ADJUSTMENT TO ILLNESS ☐ LONG RANGE PLANNING AND DECISION MAKING

Patient Name: _____ Med. Record #: _____

## GOALS/REHABILITATION POTENTIAL (Optional) CMS 485 (POC)

22 **Included as reference only, your Professional Staff must review/update/personalize/approve the goals.**

### SN - GOALS

- ☐ General: MR/MS _____ WILL EXHIBIT VITAL SIGNS WITHIN ACCEPTABLE RANGE AND STABILIZED DISEASE PROCESS. VERBALIZES KNOWLEDGE OF DISEASE MANAGEMENT, MEDICATIONS, SIDE EFFECTS, PRECAUTIONS, DIET, FLUIDS, TREATMENT PROGRAM, S/S NECESSITATING MEDICAL ATTENTION, EMERGENCY CARE.
- ☐ Psychiatric: STABILIZATION OF PSYCHOLOGICAL STATUS WITHIN DISEASE LIMITS. TO REDUCE THE PATIENT'S ANXIETY LEVEL. DEPRESION/ANXIETY CONTROLED TROUGH MED. REGIMEN/INTERVENTIONS.
- ☐ Anemia: ANEMIA CONTROLLED THROUGH MED. REGIMEN. IMPROVED HEMATOLOGIC STATUS.
- ☐ Wound Care: HEALED WOUND WITHOUT INFECTION OR COMPLICATIONS. DEMONSTRATE PROPER WOUND CARE.
- ☐ Decubitus: HEALED DECUBITUS WITHOUT INFECTION OR COMPLICATIONS. DEMONSTRATE PROPER DECUBITUS CARE.
- ☐ Alzheimer's: PT/S.O. SHOULD UNDERSTAND THE NATURE, SYMPTOMS, STAGE, AND PROGRESSION OF ALZHEIMER'S DISEASE. KNOW HOW TO RECOGNIZE PT'S OWN STRESS AND WAYS TO PREVENT OR REDUCE IT. PROMOTE SOCIAL INTERACTION AS TOLERATED BY THE PATIENT.
- ☐ Asthma: DEMONSTRATE STRATEGIES TO BE USED DURING A COUGHING EPISODE. HELP THE PATIENT IDENTIFY FACTORS THAT MAY CAUSE ASTHMA ATTACKS OR CONTRIBUTE TO THEM.
- ☐ Respiratory: UNDERSTAND S/S OF BRONCHITIS OR OTHER RESPIRATORY INFECTION, AND DISEASE EXACERBATION. UNDERSTAND THE DANGERS OF SMOKING, AIR AND CHEMICAL POLLUTANTS, AND RESPIRATORY INFECTION. UNDERSTAND AND PRACTICE COUGHING AND DEEP-BREATHING EXERCISES.
- ☐ Catheter: DAILY COMPLIANCE W/CATHETER CARE. DECREASE RISK OF URINARY INFECTION.
- ☐ Insulin: SAFELY ADMINISTERS INJECTION. COMPREHEND RATIONALE FOR AND IS ABLE TO ROTATE INJECTION SITES. COMPREHEND SAFETY FACTORS IN SYRINGE/NEEDLE DISPOSAL.
- ☐ Glucometer: PATIENT/CG ABLE TO MONITOR BLOOD SUGAR CORRECTLY WITHOUT ASSISTANCE. ABLE TO NOTIFY M.D. OF ALTERED/OUT OF RANGE RESULTS.
- ☐ Diabetes Mellitus: DISCHARGE PT WHEN BLOOD SUGARS ARE WITHIN THE NORMAL FOR PATIENT RANGE. KNOW THE ACCEPTABLE RANGE FOR BLOOD SUGAR LEVEL. COMPLY WITH DIET RESTRICTIONS..
- ☐ Fracture: RETURN TO SELF-MANAGEMENT OF HEALED FRACTURED.
- ☐ CHF: KNOW ABOUT SIGNS, SYMPTOMS, AND PRECIPITATING CAUSES OF CHF. KNOW HOW TO TAKE THE PULSE AND KNOW TO CONSULT THE DOCTOR BEFORE CONTINUING MEDICATION IF THE PULSE RHYTHM CHANGES. KNOW TO AVOID SMOKING AND SMOKY ENVIRONMENTS AND PERSONS WITH INFECTIONS, ESPECIALLY RESPIRATORY INFECTIONS.
- ☐ Hypertension: UNDERSTAND THAT HYPERTENSION IS A CHRONIC DISEASE REQUIRING LIFE LONG TREATMENT. EXHIBIT BLOOD PRESSURE READINGS CONSISTENTLY WITHIN NORMAL OR SPECIFIED RANGE. DEMONSTRATE ADHERENCE TO A LOW-SALT, LOW-FAT DIET.
- ☐ Angina: HELP THE PATIENT ACHIEVE PAIN RELIEF AND REDUCE ANGINA EPISODES. UNDERSTAND THE CAUSE OF ANGINA PECTORIS AND POSSIBLE PRECIPITATING FACTORS FOR AN ATTACK. IDENTIFY PERSONAL STRESSORS THAT MAY CONTRIBUTE TO THE PROBLEM AND BEGIN ELIMINATING OR MINIMIZING THEM. KNOW WAYS TO REDUCE THE FREQUENCY OF ANGINA EPISODES.
- ☐ Osteoarthritis: INCREASED PAIN RELIEF. INCREASED STRENGTH AND ENDURANCE. COMPREHEND AND DEMONSTRATE HOME EXERCISE.

### AIDE - GOALS

- ☐ GOOD RETURN TO PREVIOUS LEVEL OF ADLS INDEPENDENTLY.
- ☐ FAIR-TO BE ABLE TO CARRY OUT MINIMAL ADLS WITH AVAILABLE HOME SUPPORT.
- ☐ WILL NOT BE ABLE TO CARRY OUT ADLS WITHOUT MAXIMUM SUPPORT.
- ☐ RETURN TO INDEPENDENT AMBULATION. BE SAFE IN SELF CARE.
- ☐ PATIENT WILL BE ABLE TO FUNCTION WITH ASSISTANCE OF CAREGIVER WITHIN HE/SHE CURRENT LIMITATIONS AT HOME.
- ☐ PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATIONS AT HOME.

### PT - GOALS

- ☐ GAIT PATTERN, ENDURANCE, STRENGTH AND BALANCE WILL IMPROVE AND PATIENT WILL DEMONSTRATE CORRECT BODY MECHANICS W/IN 4-6 WKS. PT/CG WILL COMPREHEND AND DEMONSTRATE HOME EXERCISE PROGRAM WITHIN 4-6 WKS.
- ☐ GAIT PATTERN, ENDURANCE, STRENGTH AND BALANCE WILL IMPROVE AND PT WILL DEMONSTRATE CORRECT BODY MECHANICS WITHIN _____ WEEKS.
- ☐ PATIENT WILL EXPERIENCE A DECREASE IN PAIN
- ☐ PT/CG WILL COMPREHEND AND DEMONSTRATE HOME EXERCISE PROGRAM WITHIN _____ WEEKS.

### OT - GOALS

- ☐ OT: PATIENT WILL EXHIBIT IMPROVEMENT IN COPING IN ADL'S/IADL'S/ MUSCLE USE/MOTOR COORDINATION/NEURO RESPONSE/USE OF ORTHOTIC/ SPLINTING AND/OR EQUIPMENT.

### ST - GOALS

- ☐ PATIENT WILL DEMONSTRATE FUNCTIONAL COMMUNICATIONS, EXHIBIT MAXIMUM VERBAL AND SENTENCE FORMULATION AND COMPREHENSION WITHIN DISEASE LIMITS WITHIN ____ WEEKS.
- ☐ PATIENT WILL DEMONSTRATE APPROPRIATE USE OF FUNCTIONAL VERBAL/NON-VERBAL COMMUNICATIONS SYSTEMS WITHIN _____ WEEKS.
- ☐ PATIENT WILL DEMONSTRATE IMPROVED READING/WRITING, USE OF GESTURES/NUMBERS WITHIN ____ WEEKS.
- ☐ PATIENT WILL DEMONSTRATE IMPROVED SWALLOWING/CHEWING/ORAL/MOTOR CONTROL WITHIN ____ WEEKS.

### MSW - GOALS

- ☐ PATIENT WILL HAVE ADEQUATE SUPPORT TO REMAIN IN HOME WITH ASSISTANCE OF COMMUNITY RESOURCES FOR FINANCIAL, TRANSPORTATION AND PERSONAL CARE ASSISTANCE WITHIN ____ WEEKS.
- ☐ PSYCHOSOCIAL EVALUATION WILL BE PERFORMED. PT/CG WILL BE COUNSELED REGARDING MANAGEMENT & ADJUSTMENT TO ILLNESS /LONG TERM PLANNING AND DECISION MAKING. APPROPRIATE COMMUNITY RESOURCE REFERRALS WILL BE MADE.

**DISCHARGE PLANNING DISCUSSED WITH PATIENT:** ◯Yes ◯No

- ☐ WILL DISCHARGE THE PATIENT WITHIN 60 DAYS WHEN PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.

**REHAB POTENTIAL:** ◯Poor ◯Fair ◯Good ◯Excellent

- ☐ ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. WILL BE DISCHARGE WHEN MAXIMUM FUNCTIONAL POTENTIAL REACHED.

### COMMENTS

QA Date Reviewed:_____/_____/_____