CHERRY HOME
HEALTH SERVICES, INC.

INITIAL VISIT INFORMATION CHECKLIST

PATIENT NAME (Last, First)	CR#	EMP. INITIALS/#
		/

1. ☐ Agency information and disclosure brochure given.

2. Information given verbally and in writing

- ☐ Patient Rights and Responsibilities
- ☐ Complaints policy and process
- ☐ State Hotline for complaints about Home Health Services
- ☐ State Hotline for reporting abuse, neglect or exploitation
- ☐ Financial responsibility
- ☐ Advance Directives (living wills, surrogate) policy and information
- ☐ **Medication schedule**
- ☐ Biomedical Waste Management

3. Care Plan Development

- ☐ Discussed treatment ordered
- ☐ **Discussed and developed care plan including visit plan and goals**
- ☐ Therapist, Social Worker, Nutritionist will discuss specific plans and goals with the patient/patient caregiver

4. NEXT OF KIN

Name _____ *(relationship _____) Ph. #* _____

Address _____

EMERGENCY CONTACT (NOT LIVING WITH THE PATIENT)

Name _____ (relationship _____) Ph. #_____

Address _____

Persons you may discuss my condition and needs with: _____

_____

5. Home Health Services Questionnaire

☐ Does anyone (agency or person) come to your home to give you any type of service (care, assistance or supplies) at this time: ☐ No ☐ Yes

Who or what company? _____ Phone #:_____

What Service? _____ How often? _____

IF ANY OTHER COMPANY, AGENCY OR PERSON COMES TO YOUR HOME TO PROVIDE ANY SERVICES, YOU **ARE EXPECTED TO CONTACT OUR AGENCY IMMEDIATELY.**

6. I have received and understand the above information and accept responsibility for any charges denied by Medicare (or my insurance) due to duplication of services.

Patient's Signature: _____

If Pt. unable to sign:
Caregiver Signature: (Relationship) _____ (_____)

RN Signature: _____ Date: _____

Chinny Nurses Registry

INITIAL EVALUATION AND NURSING ASSESSMENT

Patient _____ **Age** _____

Religion _____ **Marital Status** _____

DIAGNOSES: (List all diagnoses, surgical procedures & complications relating to present condition and dates.)	HISTORY OF PRESENT ILLNESS
ENVIRONMENTAL EXPOSURE TO POLLUTANTS/TOXIC AGENTS & DATES:	ALLERGIES
CHILDHOOD DISEASE/ IMMUNIZATIONS MILITARY HX, TRAVEL & DATES	RISK FACTORS (Circle all that apply) SMOKING DIETARY OBESITY DRUGS LACK OF EXERCISE ALCOHOL SEXUAL BEHAVIOR
HISTORY OF PERTINENT PAST ILLNESS, HOSPITALIZATIONS, SURGERY, DATES	FAMILY HISTORY - GRANDPARENTS, PARENTS, SIBLINGS

REVIEW OF SYSTEMS	COMMENTS
INTEGUMENTARY Rash, pruritus, lesions, dandruff, changes in skin, hair or nails, ulcers, wounds, incisions (describe on wound sheet)	
NEUROLOGICAL Headaches, injuries, fainting, seizures, tremors, numbness, tingling, dizziness, paralysis, changes in memory, touch, taste, smell, hearing, vision, pain and/or sx of infection in eyes or ears, tinnitus, use of glasses, contact lenses, hearing aid	
RESPIRATORY Cough and characteristics, sputum, dyspnea, wheezing, hemoptysis, congestion or discharge from nose, pain in throat, nose or chest, epitaxis, throat infections, asthma, bronchitis, pneumonia, emphysema, upper respiratory infections	
CARDIOVASCULAR Chest pain, edema, dyspnea, palpitations, hypertension, heart condition, phlebitis, trouble with circulation to the extremities	
GASTROINTESTINAL Abdominal pain, nausea, vomiting, diarrhea, constipation, hemorrhoids, indigestion, swallowing, appetite, excessive flatus or belching, changes in stool color, consistency or frequency, mouth, teeth or chewing problems, partial or complete dentures, hepatitis, diverticulitis, gallstones, peptic ulcer, colitis, ostomy.	
RENAL Difficulty in urination, dysuria, dribbling, incontinence, urgency, frequency, infections, stones	
MUSCULOSKELETAL Pain or stiffness in joints, redness, swelling, limited ROM, fatigue weakness, pain in muscles, arthritis, fractures, deformity, tumor, infection, ambulation, use of assistive devices	
ENDOCRINE Diabetes, thyroid condition, increase in thirst, appetite, urination, heat or cold intolerance, breath odor, changes in weight/stamina, fat distribution	
HEMIATOPOIETIC Anemias, bruising, previous transfusions, skin hemorrhages, petechiae, blood dyscrasias, leukemia, immune disorders	
REPRODUCTIVE Lesions on or drainage from penis or vulva, rashes or irritations on penis or vulva, vaginal infections, venereal disease, infertility, birth control, sexual difficulties, age at menarche and menopause, number of pregnancies, abortions, live births, complications during pregnancies, LMP, lumps or pain in genitalia (M or F), date of last PAP and Mammogram	
PSYCHIATRIC Depression, nervousness, mood swings, insomnia, self-concept, effect of stress, thoughts of suicide, substance abuse, ETOH abuse	

DAMAR MEDICAL CENTER, INC.

INITIAL HEALTH ASSESSMENT

Date: _____ / _____ / _____

Name: _____ D.O.B. _____ / _____ / _____ /

Age: _____ WT: _____ HT: _____ Temp: _____ Bp: _____ Pulse: _____

Chief Complaints: _____

_____

_____

History of Present Illness: _____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Childhood Illness: _____

Surgery: _____

Hospitalization: _____

Accidents: _____

Hospitalizations: _____

Allergies: _____

Current Medicines: _____

_____

_____

SOCIAL HISTORY

Smoke: □ No □ Yes Amount: _____

ETOH: □ No □ Yes Amount: _____

Drugs: □ No □ Yes Amount: _____

Religion: _____

Marital Status:

Single □ Divorced □ Separated □

Married □ Widowed □

Other: _____

IMMUNIZATIONS

Pneumococcal: _____ / _____ / _____ /

Influenza: _____ / _____ / _____ /

Rubella: _____ / _____ / _____ /

Diphtheria: _____ / _____ / _____ /

Tenatus: _____ / _____ / _____ /

Other: _____ / _____ / _____ /

FAMILY HISTORY					
	ALIVE		ILLNESSES	AGE AT DEATH	CAUSE OF DEATH
	Y	N			
MOTHER					
FATHER					
SISTERS					
BROTHERS					

REVIEW OF SYSTEMS			
	NEG	POSITIVE (circle all that apply)	REMARKS
GENERAL		weight loss - fever/chills - /nightsweats - change in appetite	
SKIN		rashes	
HEENT		vision changes - decreased hearing - tinnitus	
PULM		dyspnea - cough - hemoptysis - wheezing	
CARDIAC		chest pain - palpitations - orthopnea - edema	
GI		pain - nausea/vomiting - hematemesis - constipation - diarrhea - rectal bleeding	
GU		dysuria - hematuria - frequency/urgency	
GYN		abnormal menses - pelvic pain - vaginal discharge or bleeding	
HEME		abnormal bleeding/bruising	
NEURO		headache - seizures - weakness - numbness - paresthesias faintaing	
RHEUM		pain - swelling - stiffness - limitation of motion of joints	

	Normal	EXAMINATIONS COMMENTS: Description if abnormal
General:		
Head:		
E.E.N.T.:		
Neck/Carotids:		
Chest & Lungs:		
Breasts:		
Heart:		
Abdomen:		
G/U:		
Rectal:		
Extremities:		
Skin:		
Neurological:		
Other:		

WORKING DIAGNOSIS / PLAN

_____
_____
_____
_____
_____

Diagnosis Studies Ordered:

- ☐ EKG
- ☐ CHEST X-RAY
- ☐ MAMMOGRAM
- ☐ Vestibular
- ☐ PFT
- ☐ NCV

Labs

- ☐ CBC
- ☐ Chemistry 14
- ☐ Chemistry 8
- ☐ Cardiak Risk
- ☐ Liver Function Test
- ☐ Stool
- ☐ Thyroid Panel
- ☐ Urinalysis
- ☐ Anemia Profile
- ☐ Arthritis Profile
- ☐ Glycohemoglobin
- ☐ H. Pylori QLT
- ☐ PSA
- ☐ PT with INR
- ☐ PTT
- ☐ Sed Rate
- ☐ Other:

TREATMENT PLAN

( ) Side effects explained

Patient Education: ( ) Verbal ( ) Written

Nutrition : ( ) Regualar ( ) Low Fat ( ) Diet

Next Appointment: ___ Days ___ Weeks ___ Counseling on use/abuse of smoking, alcohol and drugs

___ Counseling on high sexual behavior

___ Safety counseling: I, e, : car seats, smoke detectors, pool fence, poisons, bike injuries, uv exposure, fire arms.

DIET: ( ) Regular ( ) Diabetic (ADA _____ Cal) ( ) Low Salt ( ) Low Fat ( ) Low Purines ( ) BRATS ( ) Low Protein ( ) Oral Rehydratation

Yes ( ) No ( ) Explanation why each test is ordered Yes ( ) No ( ) Explanation of the diagnostic results

Yes ( ) No ( ) Life Styles Modifications Yes ( ) No ( ) Risk and benefit treatment

Yes ( ) No ( ) Instruction for management & F/O Yes ( ) No ( ) Understanding & Agreement

Yes ( ) No ( ) What to expect from treatment Yes ( ) No ( ) Importance of compliance w/ treatment

Yes ( ) No ( ) BSE/TSE Yes ( ) No ( ) Discussion of other treatment options

Yes ( ) No ( ) Coordination of care w/ other supplier Yes ( ) No ( ) Instruction in case of emergency

Yes ( ) No ( ) Patient and Family instruction Referral to: _____

Prognosis: Good ( ) Fair ( ) Poor ( ) Visit Level: ( ) 99211 ( ) 99212 ( ) 99213 ( ) 99214 ( ) 99215

Next Visit: _____ Days _____ Wks _____ Mo

Next Appointment: _____ Days: _____ Weeks: _____ Months: _____ PRN

Provider Name: Dario Altamirano, DO **Provider Signature:** _____

FAMILY HEALTH CARE, CORP.

INITIAL and/or RESUMPTION OF CARE/RECERTIFICATION
CASE MANAGER REPORT

Patient Name:_____ MR #:_____ SOC_____

Resumption of Care Date:_____ Discharged from: _____ D/C Date: _____

DIAGNOSIS Primary Diagnosis: _____

First Secondary Diagnosis: _____

Other Diagnosis: _____

VITAL SIGNS Temp: _____ AP (Reg / Irr): _____ RP (Reg / Irr): _____

Resp* _____ BP: _____ WT: _____ HT: _____

MEDICATIONS UPON ADMISSION

Circle One:

N O C _____

N O C _____

N O C _____

N O C _____

N O C _____

OTHERS Diet _____ Allergies: _____

Lungs: _____ Pulses: _____

Edema: _____ ABD: _____ GI: _____

GU: _____ Skin: _____

Musculoskeletal: _____ Home Env: _____

Wounds: _____ Foley: _____

Functional Limitations: _____

Mental status. _____ Living Arrangements: _____

MD: _____ Next MD Appointment: _____

COMMENTS _____

SERVICE TO PROVIDE Admission Nurse: _____

SN:	FREQUENCY:
AIDE:	FREQUENCY:
PT:	FREQUENCY:
MSW:	FREQUENCY:
OTHER:	FREQUENCY:

Case Manager: _____ Date: _____

FirstRN

LISTA DE VERIFICACION DE INFORMACION DE LA VISITA INICIAL

Nombre y Apellidos	Número de Registro	Iniciales del Empleado / # Empl. /

He recibido una explicación en forma verbal y escrita de la siguiente información:

- ☐ Información acerca de la Agencia/Guía del Paciente
- ☐ Derechos y Responsabilidades del Paciente
- ☐ Información y directivas de la política de la Compañia (A.H.C.)
- ☐ Servicio de asistencia de idiomas
- ☐ Manejo de desperdicios biomédicos
- ☐ Listado de medicamentos
- ☐ Advertencia sobre el servicio de prácticas privadas/HIPAA
- ☐ Número telefónico del Estado para quejas referentes a Servicio de Salud a Domicilio
- ☐ Número telefónico del Estado para reportar abusos,negligencias o explotación
- ☐ Póliza para trámites de quejas/agravios.
- ☐ Derechos de privacidad del paciente de su historial clínico
- ☐ Derechos del Plan de cuidados del paciente

He recibido una explicacion en forma verbal y escrita acerca de mi responsabilidad financiera:

- ☐ No hay cargos al paciente por servicios de Medicare no duplicados.
- ☐ Me ha sido provisto el acuerdo de Servicio al paciente
- ☐ Existe un co-pago de 2.00 dolares por servicios de Medicaid

---

He revelado la siguiente información para preveer cualquier duplicado de este servicio:

☐ Otras agencias/personas que hayan venido a mi casa para ofertar servicios de cualquier tipo (incluyendo cuidado,asistencia,o materiales):

Compañía: _____ Telefono: _____

Servicios prestados _____ Con qué frecuencia_____

☐ Yo comprendo que mientras estoy recibiendo servicios de Medicare y materials de esta Agencia de Cuidado, ninguna otra agencia/persona podrá recibir pagos hechos por Medicare durante ese período de servicio.

☐ Yo comprendo que debo de contactar immediatamente a la agencia si,en cualquier momento durante, el período de cuidado, otras agencies/personas vienen a mi casa a proveer el servicio/materiales o si yo tengo la intención de recibir este servicio ambulatorio.

Yo comprendo que la agencia realiza visitas de supervisión para asegurarse de la calidad y conveniencia de mi cuidado:

☐ Estoy de acuerdo de dejar a la agencia realizar visitas de supervisión a las asistentes de enfermería, enfermeros, así como a los asistentes de terapia, de acuerdo a la política de la Agencia.

Yo comprendo que voy a recibir los siguientes servicios:

- ☐ Enfermería
- ☐ Terapia Física
- ☐ Terapia de Habla
- ☐ Terapia Ocupacional
- ☐ Asistente de Enfermería
- ☐ Trabajador Social

El personal de la Agencia puede tartar el tema de mis condiciones y necesidades con la(s) persona(s) siguiente(s):

Nombre_____ Parentesco_____ Telefono #_____

Dirección:_____

Yo he comprendido toda la información presentada y acepto las responsabilidad por cualquier cargo rechazado por Medicare(o mi seguro) debido a duplicación del servicio.

Firma del paciente: _____

(Si el paciente esta incapacitado para firmar):

Firma del Responsible por el paciente:_____ Parentezco: _____

Firma de la/el Enfermera(o) Registrada(o)/Terapeuta:_____ Fecha:_____

ABANA HEALTH CARE, INC.

CONFIRMATION/ATTESTATION FORM

INITIAL PHYSICIAN´S ORDERS

VERBAL / TELEPHONE / FAX

PLAN OF CARE PERIOD: FROM: _____ TO: _____ DATE ORDERED: _____

PATIENT'S DATA:

LAST NAME	FIRST NAME & MIDDLE INITIAL	PHONE
ADDRESS	CITY	ZIP CODE
MEDICARE / MEDICAID NUMBER	SOCIAL SECURITY NUMBER	DOB

PHYSICIAN'S DATA:

LAST NAME	FIRST NAME & MIDDLE INITIAL	UPIN #
ADDRESS	CITY	ZIP CODE
PHONE	FAX	

NAME OF CALLER : _____ DISCIPLINE: ☐ RN ☐ HHA ☐ PT ☐ OT ☐ ST ☐ MSW

(INTAKE COORDINATOR)

DX:

SN: [ ] OBSERVATION & COMPLETE SYSTEMS ASSESSMENT, V/S [ ] ASSESS PT'S RESPONSE TO NEW/CHARGED MEDS/TREATMENTS

[ ] REPORT CHANGES/UNFAVORABLE RESPONSES TO MD [ ] TEACH REGARDING NEW MEDICATION REGIMEN & SIDE EFFECTS

[ ] WOUND CARE [ ] PAIN ASSESSMENT/MANAGEMENT [ ] SKILLED OBSERVATION OF WOUND SITE

[ ] TEACH SYMPTOMS TO REPORT NURSE, MD, 911 [ ] TEACH PROPER DIET/HYDRATION [ ] TEACH SAFETY PRECAUTIONS

OTHERS:

FQ:

AIDE: [ ] ADL/PERSONAL CARE ASSISTANCE

FQ:

PT: [ ] EVALUATION / TREATMENT	OT: [ ] EVALUATION / TREATMENT	ST: [ ] EVALUATION / TREATMENT
FQ:	FQ:	FQ:

MSW: [ ] EVALUATION [ ] FOLLOW FQ: _____

I ATTEST THAT I AM THE PHYSICIAN CARING FOR THE ABOVE PATIENT AND ORDERING HOME HEALTH CARE WITH ABANA HEALTH CARE, INC. FOR THE ABOVE POC PERIOD. I AGREE WITH THIS ORDER.

PHYSICIAN'S SIGNATURE: _____

ORDER OBTAINED BY: _____

PROFESSIONAL SIGNATURE (RN / PT)

State regulates that a Plan of Treatment (POT) must be signed within 30 days of date of verbal orders.

*(**Original** sent to Physician for signature. **Copy** leave in patient's chart.)*

HOME CARE SERVICES PROVIDER

7000 SW 97 Ave. Suite 201, Miami, FL 33173
Ph: (305) 262-2287

Nursing Management Services
Initial Report and Request For Visits

Agency **Home Care Services Provider** HH#: _____

Patient's Last Name _____ First Name: _____

Member #: _____ MD Name: _____ Center No: _____

Vital Signs: Temp: _____ AP (Reg/Irr): _____ Resp (Reg/Irr): _____ B/P: _____

Has patient been treated for: ☐ Diabetes ☐ CHF ☐ COPD

SOC: _____ Diagnosis: _____

Allergies: _____ Mental Status: _____

Lungs: _____

Pulses and Edema: _____

ABD: _____ GI: _____ GU: _____

Skin: _____ Musculoskeletal: _____

Home Environment: _____

Wound: _____

New Meds: _____

Doctor's Orders: _____
(What is the skill?)

Homebound ☐ Yes ☐ No Why? _____

Nurse's Observations: _____

Next MD Appt:

ATTENTION RNS: THIS FOR MUST BE FILLED OUT AND FAXED BACK TO THE OFFICE WITHIN 24 HOURS AFTER THE SIGN-UP IS DONE. FUTURE VISITS FOR THE PATIENT DEPEND ON THIS FORM BEING FAXED TO-THE OFFICE AND SYMMETRY.

Nurse's Signature _____ Date _____

INITIAL CASE HOME HEALTH AGENCY

TYPE OF VISIT: ____ SOC ____ R/I ____ RECERT ____ D/C ____ OTHERS

MR#: _____ D.O.B: _____ MCARE/CAID#: _____

PATIENT NAME:_____SOC:_____

RN PROVIDING REPORT:_____DATE:___/___/__

LIVING STATUS:___ Alone ___ Caregiver ___ Other(Specify) _____

PRIMARY DX: _____

ATTENDING PHYSICIAN:_____PH#:_____

VITAL SIGNS: T_____ P_____ B/P_____ Diet_____Allergies_____

Mental Status: A____ A____ O____ Forgetful____ Confused ____

Functional Limits :___Ambulation :___Bowel/Bladder__ Contractures___ Hearing

___Paralysis __ Ambulation___ Speech ___Vision ___Bedbound/WC___ Other

Pain _____ Level_____ Location _____

Physical Therapy Orders:_____

_____

WOUNDS: _____

_____

Risk for Hospitalization:_____

Primary reason for Hospitalization risk: _____

MEDICATION: (See medication sheet) See bellow for new medication:

___SN:_____ STAFF NAME:_____

___HHA:_____ STAFF NAME:_____

___PT/OT/ST:_____STAFF NAME:_____

RN TAKING REPORT:_____ DATE:___/___/___