PEDIATRIC RECERTIFICATION 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

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

Emergency/Disaster Plan Classification Code changed from SOC: ❑ Yes ❑ No If yes, new Code: _____
(If yes complete a new Emergency/Disaster form)

New Emergency Contact from previous episode: ❑ Yes ❑ No If yes, complete:

EMERGENCY CONTACT: ____________________

Address: ____________________

Phone: ____________________ Relationship: ____________________

Evacuation Information changed from the SOC?: ❑ Yes ❑ No If yes, document registration:

____

____

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

COMPLETE BILLING CHANGES ONLY

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

FULL SYSTEMS REVIEW

Height: ________ ❑ reported ❑ actual Weight: ________ ❑ reported ❑ actual

Reported weight changes by: ❑ Caregiver/Family ❑ Nurse

Gain/Loss ________ lb. X ________ wk./mo./yr.

Comment ____________________

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)

____

____

____

Sample 305.818.5940

PEDIATRIC RECERTIFICATION EVALUATION ASSESSMENT

NAME ____________________

NUMBER ____________________

CLINICAL INFORMATION /HISTORY

PERTINENT HISTORY OF PRESENT ILLNESS ____________________

PREVIOUS CERTIFICATION PERIOD SUMMARY
OF SERVICES, DOCUMENT NEED OF RECERTIFICATION ____________________

PERTINENT FAMILY HISTORY ____________________

MEDICATION/DOSE/ROUTE ____________________

SURGERY ____________________ DATE OF OCCURRENCE ____________________

ALLERGIES: ____ NO ____ YES (Specify) ____________________

IMMUNIZATIONS ____ CURRENT ____ NEEDS (Specify) ____________________

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

TB TEST DATE/RESULTS ____________________

HOSPITALIZATIONS IN PREVIOUS PERIOD, 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 ____________________

Sample 305 818 5940

PEDIATRIC RECERTIFICATION EVALUATION ASSESSMENT

NAME ____________________

NUMBER ____________________

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
- ❑ State hotline/ABUSE number
- ❑ Advance directives information
- ❑ Emergency Plan, classification, instructions
- ❑ Agency phone numbers, address
- ❑ Client Information Handbook
- ❑ Pain Management info
- ❑ Do not resuscitate (DNR) (if applicable)
- ❑ Service Agreement/Contract
- ❑ OASIS/HIPAA Privacy Notice, Confidentiality
- ❑ Medication sheet, reconciliated/checked SG
- ❑ Home safety guidelines
- ❑ Alzheimer's, Sensory impairments 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 or 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**

Sample 305.818.5940

NAME ____________________

PEDIATRIC RECERTIFICATION EVALUATION ASSESSMENT

NUMBER ____________

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 ____

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 ____

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)' ____

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 ____

Sample 305.818.5940

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 ____

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 ____