COMPREHENSIVE IN-HOME ASSESSMENT FORM

DATE:_____ TIME IN: _____:_____ ☐ AM ☐ PM

I. CLIENT INFORMATION

Client:	DCN:	DOB: / /
Address	City	Zip Code
Phone	County	Worker

II. PHYSICIAN INFORMATION (LIST ALL DOCTORS SEEN BY CLIENT – ATTACH ADDITIONAL SHEETS IF NECESSARY.)

Primary Care Physician:	Other Physician:
City:	City:
Phone:	Phone:
Fax:	Fax:
Date of Last Visit:	Date of Last Visit:
Frequency of Visit:	Frequency of Visit:
Reason for Doctor Visits:	Reason for Doctor Visits:

III. TYPE OF VISIT

- ☐ Initial Assessment for Authorized Services
  - ☐ Skill Care ☐Personal Care
- ☐ 6 Month
- ☐ Significant Change
- ☐ Other: _____

IV. FORMAL SUPPORT SERVICES

☐ In- Home Services Provider 1: Provider 2:	☐ Home Health Services Provider:
☐HC _____ ☐PC _____ ☐ APC _____ ☐Auth. Nurse Visit _____ ☐Respite (Type) _____ ☐Delivered Meal _____ ☐Adult Day Care _____ ☐Adult Day Health Care _____	Nurse Visit _____ PT _____ OT _____ Home Health Aide: _____ Approximate Date of Discharge _____
☐ **Hospice** Provider:	☐ **Other Services**

V. HEALTH INFORMATION

Client Identified Health Problems / Concerns

Health History (Past medical history, recent hospitalizations, surgeries, illnesses such as: diabetes, anemia, cancer, Parkinson's, tumors, & etc.)

CLIENT:	**DCN:**

VI. ALLERGIES AND VITAL SIGNS

ALLERGIES:				
TEMP:	HR:	RESP:	BP_____ / _____ -(R) (L)	
HT	WT (NOW) 3 MOS. AGO		BLOOD GLUCOSE	TIME
BGM Last Calibrated	By	Last Meal	Average BG Within Last 7 Days	

VII. MEDICATION RECORD (INCLUDE BOTH PRESCRIPTION AND OVER-THE COUNTER DRUGS, HERBALS, ETC.)

MED/DOSAGE	FREQUENCY	PHYSICIAN	PHARMACY	COMMENTS

VIII. SYSTEMS ASSESSMENT

INDICATORS LISTED ARE TO AID IN THE ASSESSMENT AND ARE NOT ALL-INCLUSIVE. IF ANY OF THE SYMPTOMS ARE PRESENT, CIRCLE AND COMMENT.

Neurological: seizures; headaches; vertigo; blind; tremor; poor memory recall; HOH; hx depression; hx mental illness

(Mini-mental Status Exam and/or the Clock Drawing Test may be used for further documentation.)

Respiratory: cough; sitting upright often/always; 02 @ L/N/C/mask; Nebulizer tx; hx smoking ___ /PPD; respiratory problems

CLIENT:	**DCN:**

Cardiopulmonary: HR irregular; chest pain; pitting edema; palpitations; pedal pulses; central line; compression hose; ASHD; hypertension

Gastrointestinal: constipation; diarrhea; incontinence; nausea/vomiting; fluid intake; appetite; G-tube/NG tube; ostomy; abdomen

Musculoskeletal: unsteady gait; weakness; paralysis; contractures; falls/injuries; pain/location; arthritis, tremors

Genitourinary: dysuria; polyuria; bladder spasms; hx UTI's; dialysis; catheter; ostomy; incontinence

Integumentary: tumor; rash; bruising; skin tears; abrasions; incisions; wounds; decubitus ulcers

Diabetic feet assessed: ☐Yes ☐No

Body chart (available on DHSS Home page) may be used to document location of injuries/wounds.

IX. MOBILITY STATUS / ASSISTIVE DEVICES

X. CAREGIVER STATUS

Client has caregiver? ☐YES ☐NO Does Client need caregiver? ☐YES ☐NO if Yes, How many Hours/Days a week

_____

Caregiver able and willing to help? ☐YES ☐NO

Caregiver name /relationship:

CLIENT	DCN

XI. RECOMMEND CARE PLAN AND FOLLOW UP –Also indicate how many more RN visit with be needed if any.

XII. NARRATIVE: INCLUDE NURSING DIAGNOSES, CLINICAL ISSUES, CONCERNS, AND CLIENT SUMMARY.

XII. SAFETY ISSUES INCLUDE POTENTIAL DANGERS (ANIMALS, DRUGS, WEAPONS, VIOLENT BEHAVIOR, ETC.); COMMUNICABLE DISEASES; OTHER. DESCRIBE CLIENT'S BACKUP PLAN IF IN-HOME SERVICES ARE INTERRUPTED FOR ANY REASON.

CLIENT NAME & SIGNATURE:	**DATE:**
NURSE NAME & SIGNATURE:	**DATE:**

TIME OUT: _____:_____ ☐ AM ☐ PM