Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Nursing Care Consultant Assessment

DATE OF VISIT	☐ ANNUAL ☐ SIX (6) MONTH
DATE OF LAST VISIT	
TIME OF VISIT FROM	TO
☐ AM ☐ PM	☐ AM ☐ PM
PRISM SCORES	
LAST YEAR'S PRISM SCORE:	
CURRENT PRISM SCORE:	

Client Demographic Information

CLIENT'S NAME	SEX ☐ Male ☐ Female	AGE	DATE OF BIRTH
ADDRESS			TELEPHONE NUMBER
PARENT / GUARDIAN'S NAME			TELEPHONE NUMBER
INDIVIDUALS PRESENT FOR ASSESSMENT			
FAMILY SUPPORT			
NURSING AGENCY / AGENCIES	CURRENT NURSING HOURS		TELEPHONE NUMBER(S)
CASE RESOURCE MANAGER			TELEPHONE NUMBER

PERSONAL CARE HOURS	RESPITE HOURS	PERSONAL CARE PROVIDER

PROVIDER	SPECIALTY	LAST VISIT	OUTCOME

Diagnosis

DIAGNOSIS		
ALLERGIES		
WEIGHT	HEIGHT	TPL / MCO

Vaccinations

Up to date on vaccinations?	☐ Yes	☐ No
Decline vaccinations?	☐ Yes	☐ No
Influenza?	☐ Yes	☐ No
Pneumococcal?	☐ Yes	☐ No

Laboratory Work / Procedures

ED Visits / Hospitalizations

Upcoming Surgeries / Procedures

Medications

Updates / changes:

Communication

Verbal communication:
Method of communication:
Ability to express wants / needs:
Ability to ask for help in the event of an emergency:

Developmental

Cognitive (developmental milestones):
Motor functions:
Social interactions:
Behavioral:

Respiratory

Vented: ☐ Yes ☐ No
Vent schedule:
Vent settings:
Trach: ☐ Yes ☐ No. If Yes, reason:
Trach change frequency:
Who does the trach change:
Trach care frequency:
Trach suctioning frequency:
Oral suctioning frequency:
Nasal suctioning frequency:
Requires oxygen: ☐ Yes ☐ No
Oximeter frequency:
Passy Muir Valve (PMV) use / tolerance:
Heated Moisture Exchange: ☐ Yes ☐ No
Capping use / tolerance:
Nebulizer:
Cough assist:
Respiratory vest / manual CPT:
CPAP / BIPAP:
Resuscitation within the last six (6) months: ☐ Yes ☐ No

Gastrointestinal

Specialty diet:
Oral feeder: ☐ Yes ☐ No
GT / JT: ☐ Yes ☐ No
Stoma care:
Tube feeding schedule and rate:
Venting schedule:
Measurement of I & O:
Continent of bowel: ☐ Yes ☐ No
Bowel program:
Continent of bladder:
Use of catheter ☐ Yes ☐ No:

Neurology

History of seizures / type / frequency / intervention:

Pain type / location / relieved by:

Cardiac

Endocrinology

Vascular

Central lines:

- PICC:
- Hickman:
- Broviac:
- Who performs nursing task:

Musculoskeletal

Musculoskeletal limitation:

- Mobility:
- Equipment used:
- Equipment needed:

OT / PT / SLP:

Integumentary

Skin integrity / pressure injuries:

History of pressure injuries:

Skin Observation Protocol triggered: ☐ Yes ☐ No

- Who was SOP referred to:
- Date:

Wound care:

Nursing Care Description

Per shift:

- AM:
- PM:
- NOC:

Emergency Preparedness

Correct size of ambulatory bag, for resuscitation (what size):

Emergency to go bag: ☐ Yes ☐ No

Back-up ventilator / concentrator: ☐ Yes ☐ No

Back-up batteries:

Are you connected with local police / fire departments: ☐ Yes ☐ No

Do you have a telephone to use in the event of an emergency: ☐ Yes ☐ No

Additional assistance / supports needed:

Community Inclusion

School name and schedule:

Client Observation at Time of Visit

Summary of Nursing

CLINICAL CRITERIAL TOOL SCORE

ISSUES / CONCERNS

The information in this document, from my observations, is true and accurate. The information in this document, as reported to me, is accurately recorded.

SIGNATURE	DATE	TITLE	INITIALS