NURSING ASSESSMENT/MONITORING FOR

◯ Living Choice ◯ Medically Fragile

Participant Name:		**SoonerCare ID #:**	
DOB:	**Phone:**	**Time in:**	**Time out:**
Nurse completing document: (please print)		**Agency:**	**Date:**
Transition Coordinator & TC agency:		**Date copy sent to TC:**	

Visit Type

☐ Initial nurse evaluation, IDT (complete pages 1, 2, & 3) ☐ Reassessment, IDT (complete pages 1, 2, 3, & 4)
☐ 6 month evaluation (complete pages 1, 2, 3, & 4)
☐ ASR supervision (complete pages 1, 2, & 4) ☐ Skilled nurse visit (complete box below) (complete pages 1 & 2)

Reason for SN visit (check all that apply): ☐fill med box ☐foot care ☐wound care ☐catheter change ☐lab draw ☐other:

Diagnoses: ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ COPD ☐Other

Visit to any of the following in the past 6 months? *Check all that apply*

☐Hospital	☐Emergency room	☐Nursing Facility	☐Behavioral health facility
Date(s): _____	Date(s): _____	Date(s): _____	Date(s): _____
Comments: _____	Comments: _____	Comments: _____	Comments: _____

Physicians / Health Practitioners

Practitioner Name	Specialty	Date last seen	Phone

ASSESSMENT

VS	BP: _____/ _____	Pulse: _____	Respirations: _____	Height: _____	Weight: _____

Neurological:

Mental/Behavioral Health:

Integument:

Cardio/Pulmonary:

Nutrition:

Elimination:

Mobility:

Sleep:

Pain:

Details specific to Participant's current chronic health condition(s):

Equipment/Supplies Participant is Currently Using: ☐Cane ☐Wheelchair ☐Walker ☐Glasses ☐Shower Chair ☐ Hand Held Shower ☐ Grab Bars ☐BSC ☐Incontinent Supplies ☐ Hearing Aid ☐Other: _____

Details of skilled care provided:

Participant's response to care:

Medications

Name of Medication	Dose	Route	Frequency	Purpose	Date Filled	Physician

Allergies

Pharmacy Information

Name: _____
Phone: _____

Medication Information

Medication administered by: ☐Self ☐Family/friend/other (list name and relationship): _____
Uses med planner: ☐Yes ☐No If yes, filled by: _____

Signatures *(If Participant signs with a mark, two witnesses are required.)*

Participant or Legal Agent	*Date*_____	*Witness*	*Date*_____
Nurse completing document	*Date*_____	*Witness*	*Date*_____

Needs Assessment Summary

Participant Name:	**SoonerCare ID #:**

Needs Assistance With
***KEY**
Who: S = Self P = PCA I = Informal O = Other **Freq:** How often is assistance needed?
PCA hrs/wk: If PCA performs or assists w/ task, designate the amount of time needed in this column.

ADL's				**IADL's**			
Task	**Who***	**Freq***	**PCA hrs/wk***	**Task**	**Who***	***Freq**	**PCA hrs/wk***
Dressing				**Shopping/Errands**			
Bathing				**Cooking/Meal Prep**			
Grooming				**Housekeeping**			
Toileting				**Laundry**			
Eating				**Money Management**			
Mobility/Transfer				**Telephone**			
Standby Assist				**Heavy Chores**			
				Medication Assist			
				Transportation			

Respite **Hours/wk**

Respite provided by:_____
Comments: _____

Advanced Supportive Restorative (ASR) Tasks **Hours/wk**

☐ Transfers ☐ Specialty Lift ☐ Catheter Care ☐ Ostomy Care ☐ Range of Motion ☐ Bowel Program
☐Other: _____

Safety Concerns

How long can Participant be home alone? ☐ Unlimited ☐ Short Periods ☐ Requires 24/7 supervision
(If "Unlimited" is not checked, please explain why in the comment box)

☐No concerns ☐Health status ☐Recent fall ☐Change in supports ☐Environment ☐Finances ☐Change in mental status
☐Unintentional weight loss ☐Equipment needs ☐Unmet supervision needs ☐Active APS case
☐Other: _____

Comments:

Current Other Agency Involvement:

☐Yes ☐No If yes, list name, service provided and contact information
_____

Resources

☐Medicare	☐Veterans Benefits	☐Private Pay	☐Indian Health Services
☐Private Health Insurance: _____	☐Vocational Rehabilitation	☐Community Organization: _____	☐Independent Living Center
☐State Plan	☐Hospice: _____		☐Other: _____

Comments:

Recommendations

☐ Adult Day Health	☐ Respite	☐ Home Delivered Meals	☐ Hospice
☐ 24 hr. Supervision	☐ Mental Health Referral	☐ Nutritional Supplements	☐ Skilled Nursing
☐ ASR SN Monitoring	☐ Dietitian	☐ PERS	☐ Therapy ☐OT ☐PT ☐ST
☐ Environmental Modification(s):(Describe) _____		☐ Other: _____	

Comments:

Equipment &/or Supplies Needed:

Signatures *(If Participant signs with a mark, two witnesses are required.)*

Participant or Legal Agent	*Date* _____	*Witness*	*Date* _____
Nurse completing document	*Date* _____	*Witness*	*Date* _____
Transition Coordination (only applicable to IDT meetings)	*Date* _____		

PCA/ASR Supervisory Visit Report

Participant Name:	**SoonerCare ID #:**

Name(s) of current worker(s) and relationship to Participant: _____

PCA/ASR present at time of visit? ☐**Yes** ☐**No**
Amount of time allotted for PCA tasks: _____ **Amount being delivered:** _____
Amount of time allotted for ASR tasks: _____ **Amount being delivered:** _____

Assigned Task(s):

☐Bed Bath	☐Hair Care	☐Dusting	☐Vacuuming	☐Clean Kitchen	☐Bed Making
☐Tub Bath	☐Skin Care	☐Sweeping	☐Meal Prep	☐Dishes	☐Laundry
☐Shower	☐Standby Assist	☐Mopping	☐Clean Bathroom	☐Trash Removal	☐Advanced Meal Prep
☐Shampoo	☐Errands	☐Other: _____			

Advanced Supportive Restorative Task(s):

☐Transfers ☐Specialty Lift ☐Catheter Care ☐Ostomy Care ☐Range of Motion ☐Bowel Program
☐Other: _____

Details of ASR task(s) performed: _____

Are PCA/ASR's current skills adequate to perform tasks? ☐ Yes ☐ No (specify) _____

Questions for the Participant &/or Responsible Party

Are the above tasks performed to your satisfaction? ☐Yes ☐No ☐Sometimes
Comment: _____

Does the aide stay the entire time allotted? ☐Yes ☐No ☐Sometimes
Comment: ___

Are you contacted if the aide is unable to come at the scheduled time? ☐Yes ☐No ☐Sometimes
Comment: ___

Do you feel respected by the aide? ☐Yes ☐No ☐Sometimes
Comment: ___

Who do you contact if the aide does not show up? ___

Does the agency offer to send a replacement aide? ☐Yes ☐No ☐Sometimes
Comment: ___

Who fills in if a replacement aide is not available? ___

Is the current plan meeting your needs? ☐Yes ☐No
Comment: ___

Nurse's Recommendations

☐ **No Changes** ☐ **Increase Services** ☐ **Decrease Services**
Justification:

Signatures *(If Participant signs with a mark, two witnesses are required.)*

Participant or Legal Agent	*Date* _____	*Witness*	*Date* _____
Nurse completing document	*Date* _____	*Witness*	*Date* _____
Nurse Supervisor (if applicable)	*Date* _____		