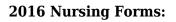
# Nursing Assessment for Home Care

Patient Informa	tion:							
Last Name:	0-102/01/01			First Name:			Mid die Initial:	
ADAP ID Number	ADAP ID Number: 555- Social Security Number:							
Contact Person (N	Jame & Relat	ionship):						
Contact Phone (D	ay-time ):			Please submit	release to at	low Program	n contact.	
Living Situation								
Dwelling: D Appr	tonent D Ho	use D Othe		Floor:# of R	nomik:	Elevator: D	Yes DiNo	
				ving in the home:		100 F01011. 10		
List the services, I	hours and da	ys they are a	vallable an	d able to assist with care givi	ng:			
Hospitalization	10							
Hospital Name:				Address				
Hospitalized: From	mar.	Too		Diagnoses:				
Hospital Contact: Phone:								
Patient Status:								
Is passent alert?	D. Always		Charles and	ient direct a home care work	art D Yes	DNo		
in gradenin alemin	G Sometim	-8-5		to is responsible for directing		100 110 100		
	□ Never			Letationship:				
Pasient Height		Patent Weig						
		Recent sign	dicant weig	phtioss7 DiYes DNo I	f Yes, amoun	llost		
Impairments:				20				
Sensory:				Muscular/Motor:				
	None	Partial	Total		None	Partial	Total	
1. Speech	-	0	130	1. Hand/Arm	-	13	- 0	
2. Sight	-			2. Upper Extremities			13	
3. Hearing	0	0	0	3. Lower Extremities	9	0	0	
Cardiovascular/	Respiratory	Y						
	None	Partial	Total	Describe impact on func	Sonal ability.			
1. Respiratory	- 0		- 0					
2. Cardiac			-	518.9;				
3. Circulatory		0						
1. Does patient ha	we history of	hubenowlosis?		Yes Q No	Gillistra puln	nomary		
2. Did patient com-	plete therapy	7	(D)	Yes CI No				
3. Does patient ou	mendy have	tuberculos is 7	ia.	res D No D Pulmonary	G Extra puls	nonary		
4. Is patient curren	ntly on tubero	ulosis prophy	daxis7 D	Yes Q No Hx of TB prop	hytaxis 🗀 Ye	is D No		
5. Last documente	ed PPD: Date	and result		Anergy results if	available:			
6. If on tuberculo s	is treatment.	are there 3 n	egative Af	87 D Yes D No Negati	ve shest k-ra	y. O Yes O	No	

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**SA Adler** 



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