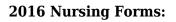
Nursing Assessment for Home Care

Patient Informa	tion:							
Last Name:	0-102/01/01			First Name:			Mid die Initial:	
ADAP ID Number: 555- Social Security Number:								
Contact Person (N	iame & Relat	ionship):		THE RESIDENCE OF THE PROPERTY				
Contact Phone (D	ay-time):			Please submit	release to at	Now Program	n contect.	
Living Situation								
Dwelling: D Apar	tment D Ho	use D Othe	r.	Floor:# of R	ooms:	Elevator: Q	Yes D No	
				lying in the home:				
					2.220			
List the services, r	hours and da	ys they are a	vallable, an	d able to assist with care givi	ng:			
Hospitalization								
Hospital Name:				Address				
Hospitalized: From	marin .	To:		Diagnoses:				
Hospital Contact Phone:								
Patient Status:								
Is oa tent alect?	D Always		Can par	ient direct a home care work	er? D Ves	DNo		
	☐ Sometim	es:		to is responsible for directing		100 110 100		
	□ Never		Name/F	Retationship:	An entre of the control of the contr			
Pasient Height		Patent Weig						
		Recent sign	Micant weig	phtioss7 DiYes DNo I	f Yes, amoun	llost		
Impairments:				20				
Sensory:				Muscular/Motor:				
	None	Partial	Total		None	Partial	Total	
1. Speech		O.	-	1. Hand/Arm	(3)	- 13	- 0	
2. Sight	-			2. Upper Extremities	100			
3. Hearing	0	0	0	3. Lower Extremities	9	0	9	
Cardiovascular/	Respiratory	Y						
	None	Partial	Total	Describe impact on func	So nat ability.			
1. Respiratory	- 0	(3)						
2. Cardiac								
3. Circulatory	0	9				22-		
1. Does patient ha	we history of	fuberculosis'		res G No G Pulmonary	Ci Extra puln	nomary		
2. Did patient com-	ple te therapy	er.	(a)	Yes 🗆 No				
3. Does patient ou	mendy have	huberculos is 7	13.	res D No D Pulmonary	O Extra puls	nonary		
4. Is patient curren					hytaxis 🗀 Ye	is D No		
5. Last documente	ed PPD: Date	and result _		Anergy results if	available:	12,4,112.		
6. If on tuberculo s	is treatment.	are there 3 n	egative AF	B7 D Yes D No Negati	ve shest k-ra	y O Yes O	No	

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Daniel F McAuley



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