

Nursing Assessment for Home Care

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

ADAP ID Number: 555- _____ Social Security Number: _____

Contact Person (Name & Relationship): _____

Contact Phone (Day-time): _____ *Please submit release to allow Program contact.*

Living Situation:

Dwelling: ☐ Apartment ☐ House ☐ Other: _____ Floor: _____ # of Rooms: _____ Elevator: ☐ Yes ☐ No

Lives alone: ☐ Yes ☐ No Identify all individuals living in the home: _____

List the services, hours and days they are available and able to assist with care giving: _____

Hospitalization:

Hospital Name: _____ Address: _____

Hospitalized: From: _____ To: _____ Diagnoses: _____

Hospital Contact: _____ Phone: _____

Patient Status:

Is patient alert? ☐ Always

☐ Sometimes

☐ Never

Can patient direct a home care worker? ☐ Yes ☐ No

If no, who is responsible for directing home care workers?

Name/Relationship: _____

Patient Height: _____ Patient Weight: _____

Recent significant weight loss? ☐ Yes ☐ No If Yes, amount lost: _____

Impairments:

Sensory:

	None	Partial	Total
1. Speech	☐	☐	☐
2. Sight	☐	☐	☐
3. Hearing	☐	☐	☐

Muscular/Motor:

	None	Partial	Total
1. Hand/Arm	☐	☐	☐
2. Upper Extremities	☐	☐	☐
3. Lower Extremities	☐	☐	☐

Cardiovascular / Respiratory:

	None	Partial	Total
1. Respiratory	☐	☐	☐
2. Cardiac	☐	☐	☐
3. Circulatory	☐	☐	☐

Describe impact on functional ability.

1. Does patient have history of tuberculosis?

☐ Yes ☐ No

☐ Pulmonary ☐ Extra pulmonary

2. Did patient complete therapy?

☐ Yes ☐ No

3. Does patient currently have tuberculosis?

☐ Yes ☐ No

☐ Pulmonary ☐ Extra pulmonary

4. Is patient currently on tuberculosis prophylaxis?

☐ Yes ☐ No

Hx of TB prophylaxis ☐ Yes ☐ No

5. Last documented PPD: Date and result _____

Anergy results if available: _____

6. If on tuberculosis treatment, are there 3 negative AFB? ☐ Yes ☐ No Negative chest x-ray ☐ Yes ☐ No

2016 Nursing Forms

Daniel F McAuley



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Table of Contents 2016 Nursing Forms

1. Understanding the eBook 2016 Nursing Forms
 - The Rise of Digital Reading 2016 Nursing Forms
 - Advantages of eBooks Over Traditional Books
2. Identifying 2016 Nursing Forms
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an 2016 Nursing Forms
 - User-Friendly Interface
4. Exploring eBook Recommendations from 2016 Nursing Forms
 - Personalized Recommendations
 - 2016 Nursing Forms User Reviews and Ratings
 - 2016 Nursing Forms and Bestseller Lists
5. Accessing 2016 Nursing Forms Free and Paid eBooks
 - 2016 Nursing Forms Public Domain eBooks
 - 2016 Nursing Forms eBook Subscription Services
 - 2016 Nursing Forms Budget-Friendly Options

6. Navigating 2016 Nursing Forms eBook Formats
 - ePub, PDF, MOBI, and More
 - 2016 Nursing Forms Compatibility with Devices
 - 2016 Nursing Forms Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of 2016 Nursing Forms
 - Highlighting and Note-Taking 2016 Nursing Forms
 - Interactive Elements 2016 Nursing Forms
8. Staying Engaged with 2016 Nursing Forms
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers 2016 Nursing Forms
9. Balancing eBooks and Physical Books 2016 Nursing Forms
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection 2016 Nursing Forms
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine 2016 Nursing Forms
 - Setting Reading Goals 2016 Nursing Forms
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of 2016 Nursing Forms
 - Fact-Checking eBook Content of 2016 Nursing Forms
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
14. Embracing eBook Trends
 - Integration of Multimedia Elements

- Interactive and Gamified eBooks

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