

INITIAL CLINICAL ASSESSMENT

MANAGEMENT OF MEDICATIONS

<p>MO780- Management of Oral Medications: <u>patient's ability</u> to prepare and take <u>all</u> prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)</p>	<p>0 1 2 3 4</p>	<p><input type="checkbox"/> Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.</p> <p><input type="checkbox"/> Able to take medication(s) at the correct times if: (a) Individual dosage are prepared in advance by another person; <u>OR</u> (b) Given daily reminders; <u>OR</u> (c) Someone develops a drug diary or chart.</p> <p><input type="checkbox"/> <u>Unable</u> to take medication unless administered by someone else.</p> <p><input type="checkbox"/> No oral medications prescribed.</p> <p><input type="checkbox"/> Unknown</p>
<p>MO790- Management of Inhalant/Mist Medications: <u>Patient's ability</u> to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <u>Excludes</u> all other forms of medication (Oral tablets, injectable and IV medications).</p>	<p>0 1 2 3 4</p>	<p><input type="checkbox"/> Able to independently take the correct medication and proper dosage at the correct times.</p> <p><input type="checkbox"/> Able to take medication at the correct times if: (a) Individual dosage are prepared in advance by another person, <u>OR</u> (b) Given daily reminders.</p> <p><input type="checkbox"/> Unable to take medication unless administered by someone else.</p> <p><input type="checkbox"/> N/A - No inhalant/mist medications prescribed.</p> <p><input type="checkbox"/> Unknown</p>
<p>MO800- Management of Injectable Medications: <u>Patient's ability</u> to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. <u>Excludes</u> IV Medications.</p>	<p>0 1 2 3 4</p>	<p><input type="checkbox"/> Able to independently take the correct medication and proper dosage at the correct times.</p> <p><input type="checkbox"/> Able to take injectable medication at the correct times if: (c) Individual syringes are prepared in advance by another person, <u>OR</u> (d) Given daily reminders.</p> <p><input type="checkbox"/> Unable to take injectable medication unless administered by someone else.</p> <p><input type="checkbox"/> N/A - No injectable medications prescribed.</p> <p><input type="checkbox"/> Unknown</p>
<p>MO810- Patient Management of Equipment (includes <u>ONLY</u> oxygen, IV/Infusion therapy, enteral/parenteral nutrition equipment or supplies): <u>Patient's ability</u> to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. (NOTE: The refers to ability, not compliance or willingness.)</p>	<p>0 1 2 3 4 5</p>	<p><input type="checkbox"/> Patient manages all tasks related to equipment completely independently.</p> <p><input type="checkbox"/> If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment.</p> <p><input type="checkbox"/> Patient requires considerable assistance from another person to manage equipment, but not independently completes portions of the task.</p> <p><input type="checkbox"/> Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.</p> <p><input type="checkbox"/> Patient is completely dependent on someone else to manage all equipment.</p> <p><input type="checkbox"/> N/A - No equipment of this type used in care.</p>

RN Case Coordinator: _____ Employee ID: _____

Patient Name: _____

Date: _____ HOVMR: _____ SEQ#: _____

HEAD No problem assessed

Dizziness Headache (describe location, duration): _____

EYES No problem assessed

Glasses Contact Lenses Blurred/double vision Glaucoma Eye Drainage: R L

Cataracts: R L PERRL Other (specify): _____

MO390- Vision with corrective lenses if the patient usually wears them:	0	<input type="checkbox"/> Normal vision: sees adequately in most situations; can see medication labels, newsprint.
	1	<input type="checkbox"/> Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.
	2	<input type="checkbox"/> Severely impaired: cannot locate objects without hearing or touching them <u>or</u> patient nonresponsive.

EARS No problem Assessed

Hearing Aid: R L Tinnitus Other (specify): _____

MO400 - Hearing and Ability to Understand Spoken Language in patients own language (with hearing aids if the patient usually uses them):	0	<input type="checkbox"/> No observable impairment. Able to hear and understands complex or detailed instructions and extended or abstract conversation.
	1	<input type="checkbox"/> With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
	2	<input type="checkbox"/> Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
	3	<input type="checkbox"/> Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
	4	<input type="checkbox"/> <u>Unable</u> to hear and understand familiar words or common expressions consistently, <u>or</u> patient nonresponsive.

ORAL No problem Assessed

Gum problems Edentulous Poor Dentation Chewing Difficulties Halitosis

Dysphagia Dentures: Upper Lower Tongue: Red Dry Swollen Coated

Mucous membranes: Dry Bleeding Lesions Hx/other: _____

MO410 - Speech and Oral (Verbal) Expression of Language (in patient's own language):	0	<input type="checkbox"/> Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
	1	<input type="checkbox"/> Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
	2	<input type="checkbox"/> Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
	3	<input type="checkbox"/> Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
	4	<input type="checkbox"/> <u>Unable</u> to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
	5	<input type="checkbox"/> Patient nonresponsive or unable to speak.

NOSE & SINUS No problem Assessed

Epistaxis Sinus irritation Altered olfactory senses Other (specify): _____

NECK & THROAT No problem Assessed

Hoarseness Difficulty swallowing (dysphagia) Dry Cough Lymphatic tenderness/enlargement

Other (specify): _____

MUSCULOSKELETAL / NEUROLOGICAL **No problem Assessed**

- Hx arthritis Gout Stiffness Swollen Joints Unequal grasp Joint pain
 Weakness Leg cramps Numbness Temp Changes Syncope Tenderness
 Deformities Comatose Tremor Aphasia/Inarticulate speech

Paralysis (describe): _____

Amputation (where/when): _____

Other (specify): _____

Coordination, gait, balance deficit (describe): No deficit noted _____

Assistive devices: _____

FATIGUE

Throughout our lives, most of us experience times when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week? **(1)**Yes **(0)**No If no, skip fatigue scale.

	NO FATIGUE	AS BAD AS YOU CAN IMAGINE									
1 Please rate your fatigue (weariness, tiredness) that best describes your fatigue right now.	0	1	2	3	4	5	6	7	8	9	10
2 Please rate your fatigue (weariness, tiredness) that best describes your usual level of fatigue during the past 24 hours.	0	1	2	3	4	5	6	7	8	9	10
3 Please rate your fatigue (weariness, tiredness) that best describes your worst level of fatigue during the past 24 hours.	0	1	2	3	4	5	6	7	8	9	10
4 Please describe how, during the past 24 hours, fatigue has interfered with your:	DOES NOT INTERFERE					COMPLETELY INTERFERES					
A. General activity	0	1	2	3	4	5	6	7	8	9	10
B. Mood	0	1	2	3	4	5	6	7	8	9	10
C. Walking ability	0	1	2	3	4	5	6	7	8	9	10
D. Normal work (includes both work outside the home and daily chores)	0	1	2	3	4	5	6	7	8	9	10
E. Relationships with other people	0	1	2	3	4	5	6	7	8	9	10
F. Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10

Adapted from the "Brief Fatigue Inventory" Charles Cleeland, 1998.

RN Case Coordinator: _____ Employee ID: _____

Patient Name: _____

Date: _____ HOVMR: _____ SEQ#: _____

PHYSICAL PAIN ASSESSMENT *Adapted from The Brief Pain Inventory by Charles S. Cleeland, 1982*

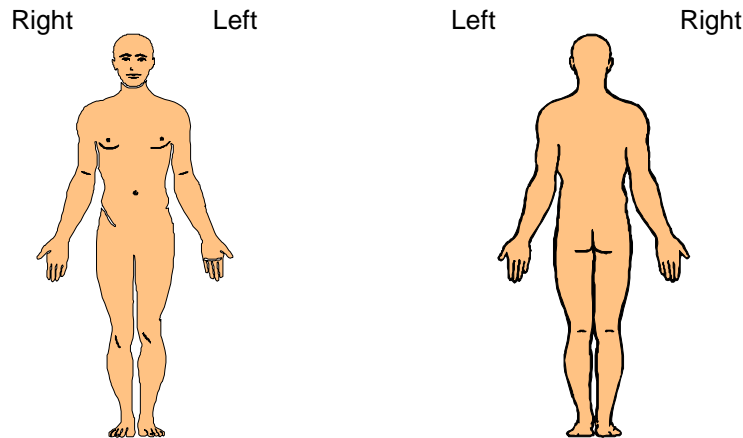
No history of pain Pain R/T Current illness Chronic illness

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain *other* than these everyday kinds of pain during the last week?

(1)Yes **(2)No**

IF THE PATIENT ANSWERED YES TO THIS QUESTION, PLEASE GO ON TO QUESTION 2 AND FINISH THIS QUESTIONNAIRE. IF NO, GO TO M0420.

2. On the diagram, shade in the areas where the patient feels pain. Put an X on the area that hurts the most.



3. Rate the patients pain by circling the one number that best describes the patients pain at its **WORST** in the past week.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Pain as bad as you can imagine

4. Rate the patients pain by circling the one number that best describes the patients pain at its **least** in the past week.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Pain as bad as you can imagine

5. Rate the patients pain by circling the one number that best describes the patients pain on **average**.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Pain as bad as you can imagine

6. Rate the patients pain by circling the one number that best describes the patients pain **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Pain as bad as you can imagine

7. What kinds of things make the patient pain feel better (for example, heat, medicine, rest)? _____

8. What kinds of things make the patients pain worse (for example, walking, standing, lifting)? _____

9. What treatments or medications is the patient receiving for pain? _____

10. In the last week, how much relief have pain treatments or medications provided? Circle the one percentage that most shows how much relief the patient has received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

11. If you take pain medication, how many hours does it take before the pain returns?

- | | |
|--|---|
| <input type="checkbox"/> 1. Pain medication doesn't help at all. | <input type="checkbox"/> 5. Four hours. |
| <input type="checkbox"/> 2. One hour. | <input type="checkbox"/> 6. Five to twelve hours. |
| <input type="checkbox"/> 3. Two hours. | <input type="checkbox"/> 7. More than 12 hours. |
| <input type="checkbox"/> 4. Three hours. | <input type="checkbox"/> 8. I do not take pain medications. |

12. Check the appropriate answer for each item. I believe my pain is due to:

- | | | |
|---|---------------------------------|--------------------------------|
| 1. The effects of treatment (for example, medication, surgery, radiation, prosthetic device). | <input type="checkbox"/> (1)Yes | <input type="checkbox"/> (0)No |
| 2. My primary disease (meaning the disease currently being treated and evaluated). | <input type="checkbox"/> (1)Yes | <input type="checkbox"/> (0)No |
| 3. A medical condition unrelated to primary disease (for example, arthritis). | <input type="checkbox"/> (1)Yes | <input type="checkbox"/> (0)No |

13. For each of the following words, check yes or no if it applies to the patient.

- | | | | | | |
|-----------|--|------------|--|-------------|--|
| Aching | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sharp | Yes <input type="checkbox"/> No <input type="checkbox"/> | Penetrating | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Throbbing | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tender | Yes <input type="checkbox"/> No <input type="checkbox"/> | Nagging | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Shooting | Yes <input type="checkbox"/> No <input type="checkbox"/> | Burning | Yes <input type="checkbox"/> No <input type="checkbox"/> | Numb | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Stabbing | Yes <input type="checkbox"/> No <input type="checkbox"/> | Exhausting | Yes <input type="checkbox"/> No <input type="checkbox"/> | Miserable | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Gnawing | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tiring | Yes <input type="checkbox"/> No <input type="checkbox"/> | Unbearable | Yes <input type="checkbox"/> No <input type="checkbox"/> |

RN Case Coordinator: _____ Employee ID: _____

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14. Circle the one number that describes how, during the past week, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal WORK (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

MO420- Frequency of Pain interfering with patient's activity or movement:	0	<input type="checkbox"/>	Patient has no pain or pain does not interfere with activity or movement
	1	<input type="checkbox"/>	Less often than daily
	2	<input type="checkbox"/>	Daily, but not constantly
	3	<input type="checkbox"/>	All of the time
MO430- Intractable Pain: Is the patient experiencing pain that is not <u>easily relieved</u> , occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity.	0	<input type="checkbox"/>	No
	1	<input type="checkbox"/>	Yes

INTEGUMENT

Integumentary Status: Dry Scaly Itching Tears Fragile Bruising Lesions
Rash Petechiae

Turgor: Poor Hot Clammy/Diaphoretic

Colors: Ashen Flushed Pale Jaundice Mottled Cyanotic

Comments: _____

NOTE: If patient has a skin lesion, open wound, pressure ulcer – complete Integument Assessment Form>

CARDIORESPIRATORY

Temperature: _____ Respirations: _____

Weight (Stated Actual): _____ Height (Stated Actual): _____

BLOOD PRESSURE:

Lying: _____ Sitting: _____ Standing: _____

PULSE:

Apical rate: _____ Rhythm: _____

Radial Rate: _____ Quality: _____ Pulse deficit

PULSE OXIMETRY:

Reading on room air: _____ Reading on _____ L/min O2: _____

CARDIOVASCULAR: No problem assessed

Palpitations Dyspnea on exertion BP problems Intermittent Claudication Fatigues easily

Paroxysmal nocturnal dyspnea Chest pain Orthopnea (# of Pillows _____) Cyanosis

Cardiac surgery (specify): _____ Pacemaker OR AICD Varicosities

Murmurs: Diastolic OR Systolic (indicate intensity): _____

Edema(indicate location & severity): _____

Other (specify): _____

RESPIRATORY: No problem assessed

Crackles: R L Rhonchi: R L Wheezing: R L Diminished: R L

Other (specify): _____

RN Case Coordinator: _____ Employee ID: _____

Patient Name: _____

Date: _____ HOVMR: _____ SEQ#: _____

Orthopnea Cyanosis: Central OR Peripheral O₂ _____ 1/min Clubbing nails
 Cough: Dry Productive Frequent Occasional
 Sputum: Amount: _____ Color: _____ Hemoptysis
 Chest: Barrel Asymmetrical Inhalers SVN
 Trach: _____ Stoma size: _____ Drainage: _____
 History of: TB Bronchitis Asthma Pleurisy Thoracentesis Pulmonary surgery
 Pneumonia Emphysema Other (specify): _____

MO490- When is the patient dyspneic or noticeably Short of Breath?	0	<input type="checkbox"/> Never, patient is not short of breath
	1	<input type="checkbox"/> When walking more than 20ft, climbing stairs
	2	<input type="checkbox"/> With moderate exertion (e.g., while dressing, using commode or bedpan, walking distance less than 20ft)
	3	<input type="checkbox"/> With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
	4	<input type="checkbox"/> At rest (during day or night)
MO500- Respiratory Treatments utilized at home (mark all that apply)	1	<input type="checkbox"/> Oxygen (intermittent or continuous)
	2	<input type="checkbox"/> Ventilator (continually or at night)
	3	<input type="checkbox"/> Continuous positive airway pressure
	4	<input type="checkbox"/> None of the above

CLINICAL SCREENING FOR TUBERCULOSIS

<input type="checkbox"/> - Negative clinical screening for Pulmonary TB <input type="checkbox"/> - Positive clinical screening for Pulmonary TB If one or more are checked with unknown origin screening is positive <input type="checkbox"/> - Nightsweats <input type="checkbox"/> - Hemoptysis <input type="checkbox"/> - Fever (unknown or unspecified origin) <input type="checkbox"/> - Productive cough (of more than 3 weeks duration) <input type="checkbox"/> - High risk population	If the patient's screening is positive, the RN Case Coordinator will follow up with the patient's physician to option either:] 1. A chest Xray (within the last 30 days) to screen for the presence of pulmonary TB <p style="text-align: center;">OR</p> 2. A statement from the physician that the patient has been examined within the past 90 days and is found by the physician to be without the signs/symptoms of pulmonary TB
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GENITOURINARY

ASSESSMENT: No problem assessed

Frequency Pain/dysuria Hematuria Vaginal discharge/bleeding Urgency
 Retention Polyuria Oliguria Nocturia Prostate disorder
 Dysmenorrhea Lesions Hx hysterectomy
 Other (specify): _____
 Urine color: _____ Cloudy Sediment Circumcised: Yes No
 Ostomy (specify type/location/supplies used): _____
 Patient independent in management Patient requires assistance in management
 Foley Suprapubic Cath
 Cath/Balloon size: _____ Date of last Δ: _____ Insertion site: Red Drainage

M0510 – Has the patient been treated for a Urinary Tract Infection in the past 14 days?	0 1 2 3	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A - Patient on prophylactic treatment <input type="checkbox"/> Unknown
M0520 – Urinary Incontinence or Urinary Catheter Presence:	0 1 2	<input type="checkbox"/> No incontinence or catheter (includes anuria or ostomy for urinary drainage) <input type="checkbox"/> Patient is incontinent <input type="checkbox"/> Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)
M0530 – When does Urinary Incontinence occurs?	0 1 2	<input type="checkbox"/> Timed-voiding defers incontinence <input type="checkbox"/> During the night only <input type="checkbox"/> During the day and night

GASTROINTESTINAL TRACT

G.I.: No problem Assessed

Last BM: _____ Bowel routine: _____

Heartburn Flatulence Hemorrhoids Diarrhea Constipation Impaction

Stool Changes Rectal bleeding Incontinent Ostomy Hx of bowel surgery: _____

Hx of bowel problems: _____ Other (specify): _____

M0540 – Bowel Incontinence Frequency	0 1 2 3 4 5 6 7	<input type="checkbox"/> Very rarely or never has bowel incontinence <input type="checkbox"/> Less than once weekly <input type="checkbox"/> One to three times weekly <input type="checkbox"/> Four to six times weekly <input type="checkbox"/> On a daily basis <input type="checkbox"/> More often than once daily <input type="checkbox"/> N/A - Patient has ostomy for bowel elimination <input type="checkbox"/> Unknown
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ABDOMEN No problem Assessed

Bowel sounds: Hyperactive Hypoactive Absent Rigid Firm Tender

Concave Ascites Distended

Abd. Girth: _____ Other (specify): _____

OSTOMY NA

Location: _____ Type: _____ Stoma Size: _____

Description: _____ Supplies: _____

Patient independent in management Patient requires assistance with management

M0550- Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, <u>OR</u> b) necessitated a change in medical or treatment regimen?	0 1 2	<input type="checkbox"/> Patient does not have an ostomy for bowel elimination. <input type="checkbox"/> Patient's ostomy was <u>not</u> related to an inpatient stay and did not necessitate change in medical or treatment regimen. <input type="checkbox"/> The ostomy <u>was</u> related to an inpatient stay, or <u>did</u> necessitate change in medical or treatment regimen.
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RN Case Coordinator: _____ Employee ID: _____

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Date: _____ HOVMR: _____ SEQ#: _____

ENDOCRINE / HEMATOPOIETIC / METABOLIC No Problem Assessed

- Diabetes: IDDM NIDDM Onset (month/year): _____
- Capillary Bloodsugar Checks: Self Caregiver Frequency: _____
- Hx thyroid Hx Hepatitis Hx blood disorder Hx Liver disease Prev. blood transfusion
- Immuno suppressed Hx. Excessive Bleeding Hx. Anemia

NUTRITIONAL SCREENING No Problem Assessed

- Oral diet prescribed: _____
- Enteral feeding: _____
- Oral supplements: _____

ONE (1) POINT	<u>TWO (2) POINTS</u>
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Active AIDs
<input type="checkbox"/> GI Mobility or Absorption Disorder	<input type="checkbox"/> Pressure Ulcer/Wounds (Stage III & IV)
<input type="checkbox"/> Renal Failure – Abnormal lab K>5.5 BUN>100	<input type="checkbox"/> Cancer or oral pharynx and/or GI tract
<input type="checkbox"/> Severe Anemia – Abnormal labs HGB<9.0, Depressed HCT, MCV, MCHC	<input type="checkbox"/> Major Burns
<input type="checkbox"/> Shortness of Breath, decreased ability to eat or drink	<input type="checkbox"/> Lab: Albumin 3.0 or less
<input type="checkbox"/> Dry mouth, mouth soreness, alteration in smell or taste	<input type="checkbox"/> COPD dependant on O ₂
<input type="checkbox"/> Special Diet (specify): _____	<input type="checkbox"/> Pitting Edema (3+ - 4+)
<input type="checkbox"/> Diarrhea lasting more than 5 days	<u>THREE (3) POINTS</u>
<input type="checkbox"/> Nausea or vomiting more than 3 days per week	<input type="checkbox"/> Lab: Albumin <2.6
<input type="checkbox"/> Oral Intake less than 50% of usual for 10 consecutive days	<input type="checkbox"/> Enteral Nutrition
<input type="checkbox"/> Involuntary weight loss in past 6 months	Other (specify): _____
<input type="checkbox"/> Pressure Ulcers/Wounds (Stage I & II)	_____
<input type="checkbox"/> Chewing Difficulties	_____
<input type="checkbox"/> Impaired Swallowing	_____
TOTAL POINTS: <input style="width: 100px; height: 20px;" type="text"/>	



- **Less than 5 points** - No dietician referral at this time
- **5-6 points** - Nurse/Dietician Telephone Consult. Dietician will make recommendations
- **7 points** - Request Dietician consult (phone contact or visit with patient)

NEURO - EMOTIONAL BEHAVIORAL

NEUROLOGICAL ASSESSMENT: No problem Assessed

- Seizures Change in LOC Paraplegia Syncope Aphasia
- Vertigo Tremor Balance problems Paresis Speech problems
- Numbness Blackouts Headaches Palsy
- Quadriplegia Dysarthria Sensory loss Tingling

Hx: _____ Other: _____

Sleep Disturbances: Patient: Yes No PCG: Yes No

Comments: _____

M0560- Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands)	0	<input type="checkbox"/> Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
	1	<input type="checkbox"/> Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
	2	<input type="checkbox"/> Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or constantly requires low stimulus environment due to distractibility
	3	<input type="checkbox"/> Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
	4	<input type="checkbox"/> Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
M0570- When Confused (Reported or Observed):	0	<input type="checkbox"/> Never
	1	<input type="checkbox"/> In new or complex situations only
	2	<input type="checkbox"/> On awakening or at night only
	3	<input type="checkbox"/> During the day and evening, but not constantly
	4	<input type="checkbox"/> Constantly
	5	<input type="checkbox"/> N/A - Patient nonresponsive
M0580- When Anxious (Reported or Observed):	0	<input type="checkbox"/> None of the time
	1	<input type="checkbox"/> Less often than daily
	2	<input type="checkbox"/> Daily, but not constantly
	3	<input type="checkbox"/> All of the time
	4	<input type="checkbox"/> N/A - Patient nonresponsive
M0590- Depressive Feelings Reported or Observed In patient: (Mark all that apply.)	0	<input type="checkbox"/> No depressive feelings reported or observed
	1	<input type="checkbox"/> Depressed mood (e.g., feeling sad, tearful)
	2	<input type="checkbox"/> Sense of failure or self reproach
	3	<input type="checkbox"/> Hopelessness
	4	<input type="checkbox"/> Recurrent thoughts of death
	5	<input type="checkbox"/> Thoughts of suicide
M0610- Behaviors Demonstrated at Least Once a Week (reported or Observed): (Mark all that apply.)	0	<input type="checkbox"/> No abnormal behaviors demonstrated
	1	<input type="checkbox"/> Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
	2	<input type="checkbox"/> Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
	3	<input type="checkbox"/> Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
	4	<input type="checkbox"/> Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
	5	<input type="checkbox"/> Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
	6	<input type="checkbox"/> Delusional, hallucinatory, or paranoid behavior

RN Case Coordinator: _____ Employee ID: _____

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MO600- Patient Behaviors (Reported or Observed): (Mark all that apply.)	0	<input type="checkbox"/>	No abnormal behaviors observed or reported
	1	<input type="checkbox"/>	Indecisiveness, lack of concentration
	2	<input type="checkbox"/>	Diminished interest in most activities
	3	<input type="checkbox"/>	Sleep disturbances
	4	<input type="checkbox"/>	Recent change in appetite or weight
	5	<input type="checkbox"/>	Agitation
	6	<input type="checkbox"/>	A suicide attempt
MO620- Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):	0	<input type="checkbox"/>	Never
	1	<input type="checkbox"/>	Less than once a month
	2	<input type="checkbox"/>	Once a month
	3	<input type="checkbox"/>	Several times each month
	4	<input type="checkbox"/>	Several times a week
	5	<input type="checkbox"/>	At least daily
MO630- Is the patient receiving Psychiatric Nursing Service at home provided by a qualified psychiatric nurse?	0	<input type="checkbox"/>	No
	1	<input type="checkbox"/>	yes

History of previous psychiatric illness: No Yes If yes, was previous treatment received?

Psychiatric institutionalization EST Psycho-Therapy Psycho-active medications

Describe: _____

PSYCHOLOGICAL DISTRESS / WELL-BEING SCREENING

Adapted from The Rand Mental Health Inventory by John E. Ware, 1979

1. During the past week, how much of the time, have you felt nervous?

- | | | |
|----------------------|----------------------------|--------------------------|
| 1 - All the time | 3 - A good bit of the time | 5 - A little of the time |
| 2 - Most of the time | 4 - Some of the time | 6 - None of the time |

2. During the past week, how much of the time, have you felt calm and peaceful?

- | | | |
|----------------------|----------------------------|--------------------------|
| 1 - All the time | 3 - A good bit of the time | 5 - A little of the time |
| 2 - Most of the time | 4 - Some of the time | 6 - None of the time |

3. During the past week, how much of the time, have you felt downhearted and blue?

- | | | |
|----------------------|----------------------------|--------------------------|
| 1 - All the time | 3 - A good bit of the time | 5 - A little of the time |
| 2 - Most of the time | 4 - Some of the time | 6 - None of the time |

4. During the past week, how much of the time, have you felt happy?

- | | | |
|----------------------|----------------------------|--------------------------|
| 1 - All the time | 3 - A good bit of the time | 5 - A little of the time |
| 2 - Most of the time | 4 - Some of the time | 6 - None of the time |

5. During the past week, how much of the time, have you felt so down in the dumps that nothing could cheer you up?

- | | | |
|----------------|------------------|------------------|
| 1 - Always | 3 - Fairly often | 5 - Almost never |
| 2 - Very often | 4 - Sometimes | 6 - Never |

Comments: _____

SPIRITUAL ASSESSMENT

1. Do you belong to a **CHURCH** or religious community? **(1)**Yes **(0)**No Specify: _____

2. How often do you go to religious **SERVICES**?

- (1)** More than once per week **(2)** Every week **(3)** Once or twice per month
 (4) Every month or so **(5)** Once or twice per year **(6)** Never

3a. To what extent do you consider yourself a **religious** person?

1. Very religious 2. Moderately religious 3. Slightly religious 4. Not religious at all

3b. To what extent do you consider yourself a **spiritual** person?

1. Very spiritual 2. Moderately spiritual 3. Slightly spiritual 4. Not spiritual at all

Adapted from FACT Quality of Life Instrument

4. In thinking about the past week, how **TRUE** are each of these statements for you?

Meaning in Life

- | | | | | | |
|---|---|---|---|---|---|
| a. I feel peaceful | 0 | 1 | 2 | 3 | 4 |
| b. I have a reason for living | 0 | 1 | 2 | 3 | 4 |
| c. My life has been productive | 0 | 1 | 2 | 3 | 4 |
| d. I have trouble feeling peace of mind | 0 | 1 | 2 | 3 | 4 |
| e. I feel a sense of purpose in my life | 0 | 1 | 2 | 3 | 4 |
| f. I am able to reach deep down into myself for comfort | 0 | 1 | 2 | 3 | 4 |
| g. I feel a sense of harmony within myself | 0 | 1 | 2 | 3 | 4 |
| h. My life has meaning and purpose | 0 | 1 | 2 | 3 | 4 |



0 - Not at all
 1 - A little bit
 2 - Somewhat
 3 - Quite a bit
 4 - Very much

Religiousness: (deter questions (i-l) if patient denies religious affiliation)

- | | | | | | |
|--|---|---|---|---|---|
| i. I find COMFORT in my faith | 0 | 1 | 2 | 3 | 4 |
| j. I find strength in my faith | 0 | 1 | 2 | 3 | 4 |
| k. My ILLNESS has strengthened my faith | 0 | 1 | 2 | 3 | 4 |
| l. I know that whatever happens with my illness, things will be okay | 0 | 1 | 2 | 3 | 4 |

5. Would you like to talk to anyone about any spiritual or religious issue?

- Yes Not at this time No