PhoenixCare
A palliative care program for our future

SUBSEQUENT CLINICAL ASSESSMENT

MANAGEMENT OF MEDICATIONS

- ☐ No change in medication orders or patient management of medication. (if No, continue to next section)
- ☐ New medications since last patient contact

Medications	Dosage	Frequency	Route	Physician Ordering	Reason For Use

Complete items below if changes in patient medication management noted.

Item	Score	Response
M0780- Management of Oral Medications: patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)	0	☐ Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	1	☐ Able to take medication(s) at the correct times if: (a) Individual dosage are prepared in advance by another person; OR (b) Given daily reminders; OR (c) Someone develops a drug diary or chart.
	2	☐ Unable to take medication unless administered by someone else.
	3	☐ No oral medications prescribed.
	4	☐ Unknown
M0790- Management of Inhalant/Mist Medications: Patient's ability 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. Excludes all other forms of medication (0ral tablets, injectable and IV medications).	0	☐ Able to independently take the correct medication and proper dosage at the correct times.
	1	☐ Able to take medication at the correct times if: (a) Individual dosage are prepared in advance by another person, OR (b) Given daily reminders.
	2	☐ Unable to take medication unless administered by someone else.
	3	☐ N/A - No inhalant/mist medications prescribed.
	4	☐ Unknown

RN Case Coordinator Name: ________________________ Employee ID: ____________

Patient Name: ____

Date: ______________ HOVMR#: ____________________ SEQ#: ____________________

M0800- Management of Injectable Medications: Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV Medications.	0	☐	Able to independently take the correct medication and proper dosage at the correct times.
	1	☐	Able to take injectable medication at the correct times if: (c) Individual syringes are prepared in advance by another person, OR (d) Given daily reminders.
	2	☐	Unable to take injectable medication unless administered by someone else.
	3	☐	N/A - No injectable medications prescribed.
	4	☐	Unknown
M0810- Patient Management of Equipment (includes ONLY oxygen, IV/Infusion therapy, enteral/parenteral nutrition equipment or supplies): Patient's ability 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.)	0	☐	Patient manages all tasks related to equipment completely independently.
	1	☐	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.
	2	☐	Patient requires considerable assistance from another person to manage equipment, but not independently completes portions of the task.
	3	☐	Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
	4	☐	Patient is completely dependent on someone else to manage all equipment.
	5	☐	N/A - No equipment of this type used in care.

HEAD / EYES / EARS

☐ No change from last assessment (if No, continue to next section)
☐ New problem identified (specify the change from the last visit): ____________________

____

ORAL / NOSE & SINUS / NECK & THROAT

☐ No change from last assessment (if No, continue to next section)
☐ New problem identified (specify the change from the last visit):

☐ Gum problems ☐ Chewing Difficulties ☐ Dysphagia ☐ Tongue: Red Dry Swollen Coated
☐ Hoarseness ☐ Epistaxis ☐ Sinus irritation
☐ Mucous membranes: Dry Bleeding Lesions ☐ Dry Cough ☐ Lymphatic tenderness/enlargement

☐ Other (specify): ____________________

Complete M0410 if change from last assessment noted

M0410- Speech and Oral (Verbal) Expression of Language (in patient's own language):	0	☐	Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
	1	☐	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	☐	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	☐	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	☐	Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
	5	☐	N/A - Patient nonresponsive or unable to speak.

MUSCULOSKELETAL / NEUROLOGICAL

☐ No change from last assessment (if No, continue to next section)
☐ New problem identified (specify the change from the last visit):

☐ Gout	☐ Stiffness	☐ Swollen Joints	☐ Unequal grasp	☐ Joint pain	☐ Weakness
☐ Leg cramps	☐ Numbness	☐ Temp Changes	☐ Syncope	☐ Tenderness	☐ Comatose

☐Tremor ☐Aphasia/Inarticulate speech

☐ Paralysis (describe): ______________________________

☐ Amputation (where/when): ______________________________

Coordination, gait, balance deficit (describe): ______________________________

Other (specifiy); ______________________________

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 Name: ______________________________ Employee ID: ______________

Patient Name: ______________________________

Date: ______________ HOVMR#: ______________ SEQ#: ______________

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

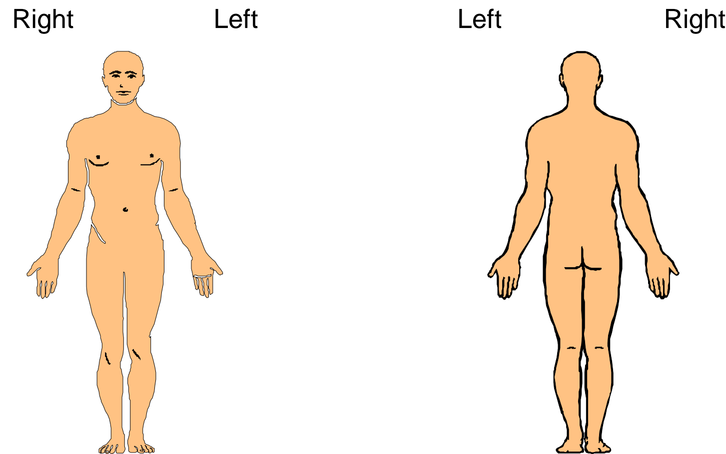
☐ No change from last assessment (if No, continue to next section)
☐ New problem identified (specify the change from the last visit):

1. Throughout our lives, most of use 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?

- ☐ 1. Pain medication doesn't help at all.
- ☐ 2. One hour.
- ☐ 3. Two hours.
- ☐ 4. Three hours.
- ☐ 5. Four hours.
- ☐ 6. Five to twelve hours.
- ☐ 7. More than 12 hours.
- ☐ 8. I do not take pain medications.

12. Circle 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). ☐ **(1)**Yes ☐ **(0)**No
2. My primary disease (meaning the disease currently being treated and evaluated). ☐ **(1)**Yes ☐ **(0)**No
3. A medical condition unrelated to primary disease (for example, arthritis). ☐ **(1)**Yes ☐ **(0)**No

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

Aching	Yes ☐ No ☐	Sharp	Yes ☐ No ☐	Penetrating	Yes ☐ No ☐
Throbbing	Yes ☐ No ☐	Tender	Yes ☐ No ☐	Nagging	Yes ☐ No ☐
Shooting	Yes ☐ No ☐	Burning	Yes ☐ No ☐	Numb	Yes ☐ No ☐
Stabbing	Yes ☐ No ☐	Exhausting	Yes ☐ No ☐	Miserable	Yes ☐ No ☐
Gnawing	Yes ☐ No ☐	Tiring	Yes ☐ No ☐	Unbearable	Yes ☐ No ☐

RN Case Coordinator Name: ________________________________ Employee ID: ______________

Patient Name: ____

Date: ______________ HOVMR#: ____________________ SEQ#: ____________________

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

M0420- **Frequency of Pain** interfering with patient's activity or movement:	**0**	☐	Patient has no pain or pain does not interfere with activity or movement
	1	☐	Less often than daily
	2	☐	Daily, but not constantly
	3	☐	All of the time

M0430- **Intractable Pain:** Is the patient experiencing pain that is not easily relieved, 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**	☐	No
	1	☐	Yes

INTEGUMENT ☐ **No problem assessed**

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

■ **Complete this section each visit**

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 change from last assessment (if No, continue to next section)

☐ New problem identified (complete assessment section below):

☐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): ______________________

RN Case Coordinator Name: ______________________ Employee ID: ____________

Patient Name: ______________________

Date: ____________ HOVMR#: ____________ SEQ#: ____________

RESPIRATORY: ☐No change from last assessment (If no, continue to next section)

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

Other (specify): ____________________

☐ Orthopnea ☐Cyanosis: ☐Central OR ☐Peripheral ☐0_2 _______ 1/min Cough: ☐Dry ☐Productive

☐Frequent ☐Occasional Sputum: Amount:_______________ Color: _______________ ☐Hemoptysis

☐Clubbing nails Chest: ☐Barrel ☐Asymmetrical ☐Inhalers ☐SVN

☐Trach:____________________ ☐Stoma size:____________________ ☐Drainage:____________________

☐Other (specify): ____________________

Complete **M0490** and **M0500** if change from last assessment noted

Item			Response
M0490- When is the patient dyspneic or noticeably Short of Breath?	0	☐	Never, patient is not short of breath
	1	☐	When walking more than 20ft, climbing stairs
	2	☐	With moderate exertion (e.g., while dressing, using commode or bedpan, walking distance less than 20ft)
	3	☐	With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
	4	☐	At rest (during day or night)
M0500- Respiratory Treatments utilized at home (mark all that apply)	1	☐	Oxygen (intermittent or continuous)
	2	☐	Ventilator (continually or at night)
	3	☐	Continuous positive airway pressure
	4	☐	None of the above

GENITOURINARY TRACT

☐ No change from last assessment (if No, continue to next section)

☐ New problem identified (complete assessment section below):

☐Frequency ☐Pain/dysuria ☐Hematuria ☐Vaginal discharge/bleeding ☐Urgency ☐Retention

☐Polyuria ☐Oliguria ☐Nocturia ☐Prostate disorder ☐Dysmenorrhea ☐Lesions

☐Other (specify): ____________________

☐Urine color:____________________ ☐Cloudy ☐Sediment Circumcised: ☐Yes ☐No

☐Ostomy (speify type/location/suplies used): ____________________

☐Patient independent in management ☐ Patient requires assistance in management

☐Foley ☐Cath/Balloon size: ____________________ Date of last Δ:_______________

Insertion site: ☐Red ☐Drainage ☐Suprapubic Cath

Complete **M0520** and **M0530** if change from last assessment noted

Item			Response
M0510 – Has the patient been treated for a Urinary Tract Infection in the past 14 days?	0	☐	No
	1	☐	Yes
	2	☐	N/A - Patient on prophylactic treatment
	3	☐	Unknown

M0520 – Urinary Incontinence or Urinary Catheter Presence:	0 1 2	☐ No incontinence or catheter (includes anuria or ostomy for urinary drainage) ☐ Patient is incontinent ☐ Patient requires a urinary catheter (i.e., external, indwelling, intermittent, surapubic)
M0530 – When does Urinary Incontinence occurs?	0 1 2	☐ Timed-voiding defers incontinence ☐ During the night only ☐ During the day and night

GASTROINTESTINAL TRACT

☐ No change from last assessment (if No, continue to next section)
☐ New problem identified (complete assessment section below):

G.I.:

☐Last BM: __________________ ☐Bowel routine:______________________________

☐Heartburn ☐Flatulence ☐Hemorrhoids ☐Diarrhea ☐Constipation ☐Impaction ☐Stool Changes

☐Incontinent ☐Rectal bleeding Other (specify):______________________________

ABDOMEN:

Bowel sounds: ☐Hyperactive ☐Hypoactive ☐Absent ☐Rigid ☐Firm

☐Tender ☐Concave ☐Ascites ☐Distended

☐Abd. Girth: ______________________ ☐Other (specify):______________________

Complete M0540 if change from last assessment noted

M0540 – Bowel Incontinence Frequency	0 1 2 3 4 5 6 7	☐ Very rarely or never has bowel incontinence ☐ Less than once weekly ☐ One to three times weekly ☐ Four to six times weekly ☐ On a daily basis ☐ More often than once daily ☐ N/A - Patient has ostomy for bowel elimination ☐ Unknown

NUTRITION SCREENING:

☐ No change from last assessment (if No, continue to next section)

☐ New problem identified (specify the change from the last visit): ______________________________

____

Oral diet prescribed: ____

☐ Enteral feeding: ______________________ ☐ Oral supplements: ________________

ENDOCRINE/HEMATOPOIETIC/METABOLIC

☐ No change from last assessment (if No, continue to next section)
☐ New problem identified (specify the change from the last visit): ______________________________

____

RN Case Coordinator Name: ______________________________ Employee ID: ______________

Patient Name: ____

Date: ________________ HOVMR#: ______________________ SEQ#: ________________

NEURO/EMOTIONAL/BEHAVIORAL/STATUS

☐ No change from last assessment (if No, continue to next section)
☐ New problem identified (complete assessment section below):

NEUROLOGICAL ASSESSMENT:

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

Other: ______________________________

Sleep Disturbances: Patient: ☐Yes ☐No PCG: ☐Yes ☐No Comments: ______________________________

____

Complete items below if change from last assessment noted

M0560- Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands)	**0**	☐	Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
	1	☐	Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
	2	☐	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	☐	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	☐	Totally dependant due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
M0570- When Confused (Reported or Observed):	**0**	☐	Never
	1	☐	In new or complex situations only
	2	☐	On awakening or at night only
	3	☐	During the day and evening, but not constantly
	4	☐	Constantly
	5	☐	N/A - Patient nonreponsive
M0580- When Anxious (Reported or Observed):	**0**	☐	None of the time
	1	☐	Less often than daily
	2	☐	Daily, but not constantly
	3	☐	All of the time
	4	☐	N/A - Patient nonresponsive
M0590- Depressive Feelings Reported or Observed In patient: (Mark all that apply.)	**0**	☐	No depressive feelings reported or observed
	1	☐	Depressed mood (e.g., feeling sad, tearful)
	2	☐	Sense of failure or self reproach
	3	☐	Hopelessness
	4	☐	Recurrent thoughts of death
	5	☐	Thoughts of suicide
M0610- Behaviors Demonstrated at Least Once a Week (reported or Observed): (Mark all that apply.)	**0**	☐	No abnormal behaviors demonstrated
	1	☐	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	☐	Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
	3	☐	Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
	4	☐	Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
	5	☐	Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
	6	☐	Delusional, hallucinatory, or paranoid behavior

M0600- Patient Behaviors (Reported or Observed): (Mark all that apply.)	**0** **1** **2** **3** **4** **5** **6**	☐ No abnormal behaviors observed or reported ☐ Indecisiveness, lack of concentration ☐ Diminished interest in most activities ☐ Sleep disturbances ☐ Recent change in appetite or weight ☐ Agitation ☐ A suicide attempt
M0620- Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):	**0** **1** **2** **3** **4** **5**	☐ Never ☐ Less than once a month ☐ Once a month ☐ Several times each month ☐ Several times a week ☐ At least daily
M0630- Is the patient receiving Psychiatric Nursing Service at home provided by a qualified psychiatric nurse?	**0** **1**	☐ No ☐ yes

PSYCHOLOGIAL DISTRESS / WELL-BEING SCREENING

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

■ **Complete on each visit**

1. How much of the time, in the past week have you felt nervous?

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

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

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

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

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

4. How much of the time, in the past week have you felt happy?

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

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

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

RN Case Coordinator Name: ______________________________ Employee ID: ______________

Patient Name: ____

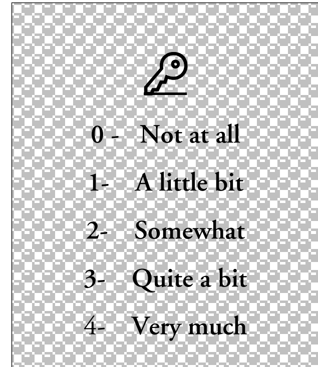
Date: ______________ HOVMR#: ____________________ SEQ#: ____________________

SPIRITUAL ASSESSMENT *Adapted from FACT Quality of Life Instrument*

1. 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



   Religiousness: (defer 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

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

   ☐ Yes ☐Not at this time ☐No

MANAGEMENT OF HOME EQUIPMENT

☐ No change in home medical equipment or patient management from last assessment (if No, continue to next section)
☐ Changes – New home medical equipment since last patient contact.

1. ______________________________ Provider: ______________________________
2. ______________________________ Provider: ______________________________
3. ______________________________ Provider: ______________________________
4. ______________________________ Provider: ______________________________

Complete items below if changes in home medical equipment management noted.

M0810- Patient Management of Equipment (includes ONLY oxygen, IV/Infusion equipment, enteral/parenteral nutrition equipment or supplies): Patient's ability 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: This refers to ability, not compliance or willingness.)			
	0	☐	Patient manages all tasks related to equipment completely independently.
	1	☐	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.
	2	☐	Patient requires considerable assistance from another person to manage equipment, but independently completes portions of task.
	3	☐	Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
	4	☐	Patient is completely dependent on someone else to manage all equipment.
	5	☐	N/A - No equipment of this type used in care.
	6	☐	Unknown

FUNCTIONAL ASSESSMENT

☐ No change in patient functional status from last assessment

☐ Changes in functional status noted – complete the Functional Status form and attach.