COMPREHENSIVE HEALTHCARE ASSESSMENT
For Persons with Disabilities

INSTRUCTIONS FOR COMPLETING FORM: This assessment should be completed upon admission and yearly thereafter by an RN or LPN. All resources available for assessment should be utilized. This should include observation in the environment, historical information obtained from reliable family members or caretakers, medical charts including all previous ancillary assessments, and information obtained from the individual being assessed, if an accurate reporter. This compiled information will be scored, with the total correlating to an identified level of nursing follow up hours that are considered necessary to sustain optimal health and well-being for an individual. This assessment can be completed any time there is a change of needs to identify the level of additional nursing follow up that is needed.
SCORING: Will be completed by adding totals from each column on the front and back of the form. Total possible points = 100 points. A total score of 1-20 points = 1 to 4 hours of nursing per month. A total score of 21-40 points = 4-8 hours of nursing per month. A total score of 41-60 points = 8-12 hours of nursing per month. A total of 61-80 points = 12-16 hours of nursing per month. A total score greater than 80 points = more than 16 hours per month nursing follow up.

Individual Name: _____ **Sex**: Male / Female **Date**: _____

Date of Birth: _____ **Age**: _____ **Agency**: _____

Diagnoses: _____

_____

_____

Current Medications, Dosage, Frequency: (may attach list or med administration record copy)
_____

_____

_____

Allergies: _____ **Current Diet**: _____

Physical Disabilities: _____

_____

Adaptive equipment: ☐ Eyeglasses ☐ Contacts ☐ Dentures / Upper / Lower ☐ Hearing Aid / Left / Right

☐ Wheelchair ☐ Walker ☐ Cane ☐ Splint / Brace Where: _____

☐ Helmet ☐ Orthopedic shoes or inserts / Right / Left ☐ CPAP / BIPAP

☐ Mealtime equipment List:
_____

☐ Positioning devices List:
_____

Communication: ☐ Communicates meaningfully ☐ Does not communicate meaningfully

☐ Uses assistive device List:
_____

☐ Special instructions for communicating:
_____

Pertinent Lab Values: ☐ Labs all within normal limits/acceptable limits for at least 1 year

☐ Abnormal lab values within last year List:
_____

_____

☐ No labs available for review

☐ Labs needed to evaluate clinical status List:
_____

Vital Signs: □ B/P _____ □ Pulse _____ □ Respirations _____
□ Temp _____

□ Current Weight _____ □ Weight 1 year ago _____ □
IBW _____

		Score			Score
I.	**DOCUMENTATION REQUIREMENTS** **ASSESSMENT DOCUMENTATION REQUIRED R/T RISKS, IDENTIFIED PROBLEMS, NEW NEEDS, F/U** **1. Once a quarter** **2. Once a month** **3. Once a week** **4. Twice a week** **5. In the past year, 2 or more episodes of more than twice a week nursing f/u + documentation req'd**		**III.**	**HEALTH HISTORY** SLEEP PATTERN 0. No sleep problems, appears well rested 1. Difficulty falling asleep and/or awakens frequently during the night and/or sleeps freq. during day 2. Incontinent during sleep times 3. Observed periods of sleep apnea or snoring	
II.	**TRAINING NEEDS** **IN THE PAST YEAR, TRAINING NEEDS WERE:** **1. Required medical orientation & yearly re-training** **2. Above in addition to quarterly training** **3. Initial medical orientation in addition to monthly medical trainings** **4. Staff monthly & prn, clients/families yearly training**			**BEHAVIOR** **0. Has no behaviors that interrupt normal schedule or activities** 1. Appears moody, anxious, depressed (maintained with quarterly psych visits) 2. Major life stressor/change with addt'l psych f/u (more than quarterly visits req'd) 3. Eats non-food items, or runs/wanders away, or history of SIB and/or hurting others 4. Police involvement within past year	
	TOTAL SCORE COLUMN 1 =			**TOTAL SCORE COLUMN 2 =**	

TOTAL SCORE
ALL COLUMNS : _____ **Signature of Nurse completing form:**

_____

COMPREHENSIVE HEALTHCARE ASSSESSMENT (SIDE 2)

		Score			Score
III.	**HEALTH HISTORY (cont'd)** **ILLNESSES DURING PAST YEAR THAT INTERRUPT NORMAL ACTIVITIES** **0. None** **1. One illness** **2. Two illnesses** **3. More than 2 illnesses (cold, flu, pneumonia, etc.)**		**VI.**	**PERSONAL CARE** **ORAL CARE** 0. Is independent in oral care 1. Requires verbal prompts to complete oral care 2. Requires physical assist to complete oral care 3. Staff must perform oral care	
	HOSPITALIZATIONS DURING PAST YEAR **0. None** **1. One hospitalization** **2. Two hospitalizations** **3. Three or more hospitalizations**			**NAIL CARE** 1. Monthly by staff 2. Weekly by staff 3. Nail care done by nurse, physician, or podiatrist 4. Medical treatment required for infections 5. Two or more of the above	
	FAMILY MEDICAL RISK FACTORS (Heart disease, Diabetes, Cancer, etc.) **0. None** **1. Has 1 risk factor** **2. Has 2 risk factors** **3. Has 3 or more or unable to obtain family medical hx**			**SKIN CARE** 1. Quarterly assessments by nurse 2. Occasional skin problems 3. Chronic skin problems requiring medications 4. Frequent skin breakdown requiring treatment 5. Two or more of the above	
	DIAGNOSES **0. No diagnoses other than DD** **1. One addt'l medical and/or psych diagnosis** **2. Two addt'l medical and/or psych diagnosis** **3. More than 2 medical and/or psych diagnoses**		**VII.**	**NUTRITION** WEIGHT MONITORING 1. Is within ideal body weight range or optimal weight for that individual (yearly weights) 2. Requires monthly weight monitoring 3. Requires weekly or more frequent weights	

IV.	**HEALTH MAINTENANCE** **YEARLY CONSULTATIONS** 0. None 1. One yearly consultation 2. Two yearly consultations 3. Three or more yearly consultations			**DIETARY NEEDS** 0. No dietary restrictions 1. Is on a weight reduction or weight gain diet 2. Is on a special diet (Low sodium, Low fat, etc.) 3. Is on enteral feedings (Ensure, Resource, etc.)	
	YEARLY LAB TESTS 0. None 1. Routine labs done once yearly only 2. Two or more lab tests done periodically 3. Regular toxicity/ therapeutic lab testing required due to medical condition or drug use			**SPECIAL FEEDING ISSUES** 0. No special mealtime needs 1. Use of thickened liquids and/or pureed or chopped foods; special eating utensils used 2. Thickened liquids and special positioning during or after mealtime is utilized 3. Tube feeding required, either pump or bolus 4. Two or more of the above are required	
	VITAL SIGN MONITORING 0. Annually only 1. Quarterly 2. Monthly 3. Weekly or more often			**MEALTIME SKILLS** 0. Is independent, no choking or aspiration issues 1. Requires constant supervision by staff 2. Requires physical assistance of staff 3. Is fed by staff or tube feeding used	
	APPTS REQUIRING STAFF ATTENDANCE 1. Annual physical only 2. At annual physical + one other appt 3. At annual physical + two other appts 4. At annual physical + three or more other appts		**VIII.**	**ELIMINATION PATTERN** **BOWEL** 0. No bowel problems, regular bowel pattern 1. Incontinent of bowel occasionally 2. Requires incontinent briefs 24 hours a day 3. Has a history of chronic constipation, diarrhea, or bowel obstruction 4. Has two or more of the above	
V.	**CURRENT MEDICATIONS** **CHANGES IN MEDICATIONS IN THE PAST YEAR** 0. None 1. One to two medication or dosage changes 2. Three medication or dosage changes 3. More than three medication or dosage changes			**URINARY** 0. No bladder problems, regular urinary pattern 1. Incontinent of urine occasionally 2. Requires incontinent briefs 24 hours a day 3. Requires catheterizations or has a history of frequent UTIs 4. Two or more of the above	
	TYPES OF MEDICATIONS 0. Does not take any medications 1. Is on some medications that do not require VS monitoring 2. Is on cardiac medication requiring VS monitoring 3. Is on at least one of these: antipsychotic, antianxiety, antidepressant, sedative/hypnotic, epileptic 4. Two or more of the above		**IX.**	**NEUROLOGICAL** **SEIZURE DIAGNOSIS** 1. Controlled 2. Has one seizure per month average 3. Has more than one seizure per month average 4. Newly diagnosed (within past year) or increase in seizure frequency or severity	
	MEDICATION ADMINISTRATION 0. Is not on any medications 1. Self-administers meds 2. Medications administered by staff 3. Medications administered by tube, nebulizer, or injection		**X.**	**SENSORY** **HEARING AND VISION** 1. Every 3 years (hearing) and every 2 years (vision) 2. Yearly exam 3. Is blind or deaf, or may require glasses or hearing aids 4. Frequent eye or ear infections requiring medication 5. Two or more of the above	
	MEDICATION ADMINISTRATION FREQUENCY 0. Does not take medications 1. One time daily or prn only 2. Two to three times daily 3. Four or more times daily		**XI.**	**SPECIAL TREATMENTS**(respiratory, ostomy care, wound care, blood sugar monitoring, other) 1. Requires one treatment per day 2. Requires two treatments per day 3. Requires three or more treatments per day	
	TOTAL SCORE COLUMN 3 =			**TOTAL SCORE COLUMN 4 =**	