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| Transforming Lives | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  **Nursing Care Consultant Assessment** | | | | | | DATE OF REVIEW | | ANNUAL  INITIAL  SIX (6) MONTH | |
| DATE OF LAST REVIEW | | | |
| PRISM SCORES  CURRENT PRISM SCORE:  PREVIOUS PRISM SCORE:  ADMIT RISK SCORE:  PREVIOUS ADMIT RISK SCORE:  TPL / MCO: | | | |
| Client Demographic Information | | | | | | | | | | |
| CLIENT’S NAME | | | | SEX  Male  Female | | | AGE | DATE OF BIRTH | | ADSA NUMBER |
| ADDRESS | | | | | | | | | | |
| PARENT / GUARDIAN’S NAME | | | | | | | | TELEPHONE NUMBER | | |
| INDIVIDUALS PRESENT FOR ASSESSMENT | | | | | | | | | | |
| FAMILY / INFORMAL SUPPORT | | | | | | | | | | |
| NURSE / NURSING AGENCY / AGENCIES | | | | | CURRENT NURSING HOURS | | | TELEPHONE NUMBER(S) | | |
| CLINICAL SUPERVISOR | | | | | | | | TELEPHONE NUMBER | | |
| CASE RESOURCE MANAGER | | | | | | | | TELEPHONE NUMBER | | |
| PERSONAL CARE HOURS | | RESPITE HOURS | PERSONAL CARE PROVIDER | | | | | | | |
| PROVIDER | | | SPECIALTY | | | LAST VISIT | | OUTCOME | | |
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| CODE STATUS |
| DIAGNOSES |

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| ALLERGIES |

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| WEIGHT | HEIGHT | VACCINATIONS  Influenza?  Yes  No Pneumococcal?  Yes  No  Comments below: |

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| Laboratory Work |

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| 911 / ED Visits / Hospitalizations / Illnesses |

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| Upcoming Surgeries / Procedures |

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| Medications |

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| Updates / changes: |

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| Communication |
| Verbal communication: |

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| Method(s) of communication: |

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| Ability to express wants / needs: |

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| Ability to ask for help in the event of an emergency: |

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| Comments: |

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| Community Inclusion |
| School name and schedule: |

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| Activities / interests: |

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| Comments: |

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| Musculoskeletal |
| Musculoskeletal limitation:  Mobility: |

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| Equipment used: |

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| Equipment needed: |

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| OT?  Yes  No PT?  Yes  No SLP?  Yes  No PROM?  Yes  No |

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| Comments: |

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| Respiratory |
| Vented:  Yes  No  Vent schedule: |

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| Trach:  Yes  No. If Yes, reason: |

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| Trach change frequency: |

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| Who does the trach change: |

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| Trach care frequency: |

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| Trach suctioning frequency: |

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| Oral suctioning frequency: |

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| Nasal suctioning frequency: |

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| Requires oxygen:  Yes  No |

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| Oximeter frequency: |

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| Passy Muir Valve (PMV) use / tolerance: |

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| Heated Moisture Exchange:  Yes  No |

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| Capping use / tolerance: |

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| Nebulizer: |

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| Cough assist: |

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| Respiratory vest / manual CPT: |

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| CPAP / BIPAP: |

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| Resuscitation within the last year:  Yes  No |

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| Comments: |

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| Genitourinary / Gastrointestinal |
| Diet: |

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| Oral feeder:  Yes  No |

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| JT:  Yes  No |

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| GT:  Yes  No |

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| Who does the tube change: |

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| Stoma care frequency: |

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| Tube feeding schedule and rate: |

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| Venting schedule: |

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| Farrell bag: |

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| Measurement of I & O: |

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| Continent of bowel:  Yes  No |

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| Bowel program:  Yes  No |

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| Continent of bladder:  Yes  No |

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| Use of catheter:  Yes  No |

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| Menstrual cycle: |

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| Comments: |

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| Neurology |
| History of seizures / type / frequency / intervention: |

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| Pain type / location / relieved by: |

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| Comments: |

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| Cardiac |

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| Endocrinology |

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| Vascular |
| Central lines:  Yes  No  Comments: |

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| Integumentary |
| Skin integrity / pressure injuries: |

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| History of pressure injuries: |

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| Skin Observation Protocol triggered:  Yes  No  Date: |
| Who was SOP referred to: |

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| Wound care: |

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| Comments: |

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| Emergency Preparedness |
| Correct size of AMBU bag for resuscitation (what size):  Yes  No  Neonatal:  Yes  No  Pediatric:  Yes  No  Adult:  Yes  No |

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| Emergency To Go Bag:  Yes  No  Back-up ventilator / concentrator:  Yes  No  N/A  Back-up batteries:  Yes  No  N/A  Generator:  Yes  No |

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| Are you connected with local police / fire departments / Smart 911:  Yes  No  Comments: |

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| Client Observation at Time of Visit |

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| Issues / Concerns |

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| NCC Recommendations |
| CLINICAL CRITERIA TOOL SCORE |

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| RECOMMENDATIONS |

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| The information in this document, from my observations, is true and accurate. The information in this document, as reported to me, is accurately recorded. | | |
| SIGNATURE DATE | TITLE | INITIALS |