Developmental Disabilities Administration (DDA)

Nursing Care Consultant (NCC) Focused Assessment

Date of Assessment:	NCC Completing Assessment
Reason for Referral:	

Assessment Type (check all that apply and complete identified section on form):

☐ Frequent Hospitalization ☐ Nutritional Status ☐ Medication Regimen
☐ Mobility ☐ Skin ☐ Unstable / Potentially Unstable Diagnosis
☐ Other:

Demographics

Client's Name	Date of Birth	Sex assigned at birth ☐ Male ☐ Female	Gender ☐ Male ☐ Female ☐ Other:
ProviderOne Number	ADSA Number	MCO / Insurance	
Parent / Authorized Representative (if guardianship in place)		Case Resource Manager	
Interpreter needed; ☐ Yes ☐ No	Preferred language	Method of communication	Ability to express wants and needs ☐ Yes ☐ No

Supports

CFC Hours ☐ Agency / IP ☐ Informal Support	Waiver	Respite Hours
Nurse Delegation ☐ Yes ☐ No / Private Duty Nursing ☐ Yes ☐ No	Skilled Nursing ☐ Yes ☐ No	Other:

APS / CPS / Incident Reports (previous 12 months) ☐ **None**

Emergency Care and Reason within the last 12 months

911 calls	Date: Reason: Outcome:
Emergency Department visits	Date: Reason: Outcome:
Urgent Care Visits	Date: Reason: Outcome:
Hospitalizations	Date: Reason: Outcome:
Code Status	Allergies

Information obtained for assessment is primarily through the DDA Assessment and client / care provider interview.

Primary Diagnosis; Obtained from:

Medical Providers

Provider Name	Specialty	Last Visit	Notes

Current Medications

Medication	Dose / Route	Time

PRN usage in the last 30 days

Changes to medications in the last six months

Frequent Hospitalizations ☐ **Not Assessed**

Prevention measures in place to prevent future hospitalization / emergency visits: ☐ Yes ☐ No

If yes, explain:

If not, are they needed: ☐ Yes ☐ No

Adequate provider support available at discharge: ☐ Yes ☐ No

Barriers to accessing services, if any (i.e., transportation, finances, appropriate staffing) : ☐ Yes ☐ No

Mental Health admission(s): ☐ Yes ☐ No

Self-Injurious behaviors / aggression: ☐ Yes ☐ No

NCC observation / notes:

Nutritional Status ☐ **Not Assessed**

Height Weight BMI	Underweight ☐ Yes ☐ No	Overweight ☐ Yes ☐ No	Goal Weight
Daily Caloric Intake	Method and Frequency of Weighing		

	Yes	No
Does the client have access to adequate food and supplies	☐	☐
Recent medical changes or concerns	☐	☐
Recent change to medical providers	☐	☐
Recent change to personal care providers / informal support	☐	☐
History of weight gain / loss; recent weight loss	☐	☐
Has there been any negative impact from weight loss:		
Recent changes in appetite	☐	☐
Medication affecting appetite	☐	☐
Contributing factors to weight loss:		
Behavioral factors:		
Reoccurring infection	☐	☐
Dental concerns	☐	☐
Depression	☐	☐
Pain	☐	☐

Interventions / supports in place: ☐ PT ☐ OT ☐ SLP ☐ Aversion Therapy ☐ Other:

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	Yes	No
Oral intake	☐	☐
Dysphagia	☐	☐
Swallow evaluation needed / completed; date completed:	☐	☐
Monitoring for choking	☐	☐
Plan in place	☐	☐
Assistance required during mealtimes	☐	☐
Positioning	☐	☐
Vision impairment	☐	☐
Hearing loss	☐	☐
Special diet instructions / cultural preferences:		
Tube feeding	☐	☐

Formula type:

Rate and schedule:

Hydration schedule:

Tube care / site integrity:

Constipation: ☐ Yes ☐ No; Diarrhea: ☐ Yes ☐ No; Vomiting: ☐ Yes ☐ No

Frequency of bowel movements:

	Yes	No
Bowel Program / plan in place	☐	☐

Method for monitoring intake and output:

NCC observation / notes:

Medication Regimen ☐ **Not Assessed**

Administration: ☐ Independent ☐ Partial Assistance ☐ Full Assistance

If assistance is needed, who performs task:

☐ Family ☐ Nurse Delegated IP / AP ☐ Nurse ☐ Other:

	Yes	No
Problems swallowing / taking medications	☐	☐
Complex medication / treatment regimen	☐	☐
Multiple medication prescribers	☐	☐
Frequently declining medications	☐	☐
If yes, why:		
Medical evaluation needed, resulting from declining of medications	☐	☐
If not, would the client benefits from a medication management system	☐	☐

NCC observation / notes:

Mobility ☐ **Not Assessed**

	Yes	No
Ambulatory	☐	☐

Activity level / preference:

Full ROM: ☐ Yes ☐ No; Limited ROM: ☐ Yes ☐ No

Number of falls in the last year:

	Yes	No
Injury related to falls	☐	☐

If yes, type of injury:

Therapy services: ☐ OT ☐ PT ☐ SLP ☐ AROM ☐ PROM ☐ Other:

	Yes	No
Environment affecting safety	☐	☐

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Medical diagnosis affecting mobility ☐ ☐
Incontinent of bowel or bladder ☐ ☐
Catheter use ☐ ☐
Medical equipment used:
Medical equipment needed:
NCC observation / notes:

Skin ☐ **Not Assessed**

	Yes	No
Skin Observation Protocol in the last 12 months; if yes, date:	☐	☐
Significant change since last skin assessment	☐	☐

Skin color: ☐ WNL ☐ Pale ☐ Cyanotic ☐ Jaundice ☐ Other:

Diagnosed skin problems ☐ ☐
If yes, explain:
Pressure injuries ☐ ☐

Location	Appearance	Treatment
1.		
2.		

History of pressure injuries ☐ ☐
If yes, site and cause:
Skin care routine:
Foul odors ☐ ☐
What has proven helpful and not helpful for skin problems:
Education provided ☐ ☐
Education needed ☐ ☐
Equipment needs ☐ ☐

NCC observation / notes:

Unstable / Potentially Unstable Diagnosis ☐ **Not Assessed**

Unstable diagnosis related to body system (check all that apply):

☐ Neurological Notes:
☐ Respiratory:
☐ Cardiovascular Notes:
☐ Renal / GU System Notes:
☐ Gastrointestinal Notes:
☐ Renal / GU System Notes:
☐ Musculoskeletal Notes:
☐ Skin Notes:
☐ Eyes Notes:
☐ HEENT – Head, Ears, Eyes, Nose, Throat:
☐ Endocrine Notes:
☐ Pain Notes:

NCC observation / notes:

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Complex medical needs: Frequent medical appointments / Emergency Department visits or hospitalization (if not, complete hospitalization section): ☐ Yes ☐ No Reoccurring infection(s): ☐ Yes ☐ No Body mass affected (if yes, complete nutrition section): ☐ Yes ☐ No Notes:	
Emergency Plan / Preparedness	
Documentation review	
Consultation notes Home Visit needed: ☐ Yes ☐ No	
NCC Recommendation	
Clinical Team Referral recommended: ☐ Yes ☐ No	
Nursing Care Consultant Signature	Date

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