|  |  |
| --- | --- |
|  |  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 |
| **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 [ ]  NoIf yes, explain: If not, are they needed: [ ]  Yes [ ]  No |
| Adequate provider support available at discharge: [ ]  Yes [ ]  NoBarriers to accessing services, if any (i.e., transportation, finances, appropriate staffing) : [ ]  Yes [ ]  NoMental Health admission(s): [ ]  Yes [ ]  NoSelf-Injurious behaviors / aggression: [ ]  Yes [ ]  NoNCC 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 NoDoes 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: 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: Bowel Program / plan in place [ ]  [ ] Method for monitoring intake and output:   |
| NCC observation / notes:  |
| **Medication Regimen** [ ]  **Not Assessed** |
|  Yes NoAdministration: [ ]  Independent [ ]  Partial Assistance [ ]  Full Assistance If assistance is needed, who performs task:[ ]  Family [ ]  Nurse Delegated IP / AP [ ]  Nurse [ ]  Other: 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 NoAmbulatory [ ]  [ ] Activity level / preference: Full ROM: [ ]  Yes [ ]  No; Limited ROM: [ ]  Yes [ ]  No Number of falls in the last year: Injury related to falls [ ]  [ ] If yes, type of injury: Therapy services: [ ]  OT [ ]  PT [ ]  SLP [ ]  AROM [ ]  PROM [ ]  Other: Environment affecting safety [ ]  [ ] Medical diagnosis affecting mobility [ ]  [ ] Incontinent of bowel or bladder [ ]  [ ] Catheter use [ ]  [ ] Medical equipment used: Medical equipment needed: NCC observation / notes:  |
| **Skin** [ ]  **Not Assessed** |
|  Yes NoSkin 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.
 |  |  |
| 1.
 |  |  |
| 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: Complex medical needs: Frequent medical appointments / Emergency Department visits or hospitalization (if not, complete hospitalization section): [ ]  Yes [ ]  NoReoccurring infection(s): [ ]  Yes [ ]  NoBody mass affected (if yes, complete nutrition section): [ ]  Yes [ ]  NoNotes:  |
| 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  |