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|  | | 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** | | | | | | | | | | | |
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| **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:** | | | | | | | | | | | |

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| **Medical Providers** | | | |
| **Provider Name** | **Specialty** | **Last Visit** | **Notes** |

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| **Current Medications** | | |
| **Medication** | **Dose / Route** | **Time** |

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| 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:  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 No  Administration:  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 No  Ambulatory  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 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** | |
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| 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  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 | | | | | | |