

Does the patient have any of the following impairments? Yes No

D. IMPAIRMENTS -

If there is an impairment, indicate by check (✓) type and degree of impairment:

SENSORY IMPAIRMENT			MUSCULAR/MOTOR IMPAIRMENT				CARDIOVASCULAR/RESPIRATORY IMPAIRMENT			
	PARTIAL	TOTAL		PARTIAL	TOTAL		TOTAL		TOTAL	
1. Speech	<input type="checkbox"/>	<input type="checkbox"/>	1. Dominant hand/arm	<input type="checkbox"/>	<input type="checkbox"/>	1. Respiratory function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Sight	<input type="checkbox"/>	<input type="checkbox"/>	2. Other hand/arm	<input type="checkbox"/>	<input type="checkbox"/>	2. Cardiac function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Hearing	<input type="checkbox"/>	<input type="checkbox"/>	3. Muscular Coordination	<input type="checkbox"/>	<input type="checkbox"/>	3. Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>					
			Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>					

ELIMINATION

(Check ✓)

	Continent	Occasionally Incontinent	Incontinent
Bladder			
Bowel			

Indicate reason for incontinence and what is currently being done:

E. MENTAL STATUS - Does the patient exhibit any of the following? Yes No If Yes, check appropriate boxes.

	Some-times	Always		Some-times	Always		Some-times	Always		Some-times	Always
1. Disoriented to place/time	<input type="checkbox"/>	<input type="checkbox"/>	4. Short-term memory impairment	<input type="checkbox"/>	<input type="checkbox"/>	7. Impaired judgement	<input type="checkbox"/>	<input type="checkbox"/>	10. Communication problems	<input type="checkbox"/>	<input type="checkbox"/>
2. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	5. Wandering	<input type="checkbox"/>	<input type="checkbox"/>	8. Danger to others	<input type="checkbox"/>	<input type="checkbox"/>	11. Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>
3. Agitation	<input type="checkbox"/>	<input type="checkbox"/>	6. Depression	<input type="checkbox"/>	<input type="checkbox"/>	9. Danger to self	<input type="checkbox"/>	<input type="checkbox"/>	12. Abusive	<input type="checkbox"/>	<input type="checkbox"/>

Describe the nature, frequency and effect on client's functioning for any area checked.
Attach additional documentation if necessary.

Is patient alert? Always Sometimes Never

Can patient direct a home care worker? Yes No If No, explain below.

F. MEDICAL TREATMENT - Does the patient need any of the following medical treatment? Yes No

Indicate medical treatment needed: (✓)

1. Decubitus care		7. Colostomy care		15. Suctioning	
2. Dressings: Sterile Simple		8. Ostomy care		16. Speech/hearing therapy	
3. Bedbound care (turning, exercising, positioning)		9. Oxygen administration		17. Occupational therapy	
4. Ambulation exercise		10. Catheter care		18. Rehabilitation therapy	
5. ROM/Therapeutic exercise		11. Tube irrigation		19. Indicate any special dietary needs	
6. Enema		12. Monitor vital signs		20. Other	
		13. Tube feeding			
		14. Inhalation therapy			

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

G. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered		Has	Needs	Ordered		Has	Needs	Ordered
Cane				Bedpan/Urinal				Bath Bar			
Crutches				Commode				Bath Seat			
Walker				Diapers				Grab Bar			
Wheelchair				Hoyer Lift				Shower Handle			
Hospital Bed				Dressings				Other (Specify)			
Side Rails				Respiratory Aids							

If any needed equipment was not ordered, what other plans have been made to meet this need?

III. IDENTIFICATION OF SERVICE NEEDS

A. Indicate ability to ambulate/transfer:

	Can	Cannot	Can with assistance of:				(Specify)
			Cane	Walker	Person	Other:	
1. ambulate inside							
2. ambulate outside							
3. Get up from seated position							
4. Get up from bed							
5. Transfer to commode							
6. Transfer to wheelchair							

B. Indicate any services needed :

A. CHORE SERVICES:

- Cleaning
- Meal Prep
- Laundry
- Shopping
- Reheat Meals

B. PERSONAL CARE SERVICES:

- | | | | | | |
|-------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|
| 1. Grooming | <input type="checkbox"/> | <input type="checkbox"/> | 5. Feeding | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dressing | <input type="checkbox"/> | <input type="checkbox"/> | 6. Toileting: Bedpan | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Washing | <input type="checkbox"/> | <input type="checkbox"/> | Commode | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Bathing | <input type="checkbox"/> | <input type="checkbox"/> | 7. Other special toilet needs: | | |

IV. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? Yes * No

* Identify AGENCY SERVICE STATUS OF SERVICE REFERRAL DATE

PHYSICIAN'S CERTIFICATION

I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and that I may be contacted for further clarification.

(PRINT) Physician's Name

Specialty

Physician's Signature

Intern
 Resident

Date Form Completed

Registry No.

Telephone No.

Hospital Contact person

Telephone No.

Indicate where form was completed:

Hospital/Clinic/Inst. Name

Address

Telephone No.

If nurse/social worker/other person assisted in completing this form:

Name

Title

Address

Telephone No.

