Cover Page

Patient Name: _____

Date of Birth: ___ /___ /_____

Gender: ○ Male ○ Female

Admission ID#: CHR - _____

Phone#: _____

Visit Date: ___ /___ /_____

Visit Type: _____

RN Name: _____

RN CODE #: CHR - _____

HHA-Profile/Info/Med Profile/Others

1. Profile

a. ☐ I confirm that I reviewed and entered all information and changes into the Profile section of EMR

b.
- **Address**
- **Phone Number Information**
- **Emergency Contact Information** - Name, Phone, Relationship
- **Emergency Preparedness** - Priority Code, TALS, Evacuation Location (plan and contact), Electronic Device Dependency
- **Physicians** - Name, Phone
- **Diagnosis**

2. Info

a. ☐ I confirm that I reviewed and entered all information and changes into the Info section of the EMR

b.
- **Allergies**
- **Advance Directives**
- **Pharmacy -** Name, Phone

3. Rights and Notices

☐ I have reviewed with the patient and/or family caregiver prior to provision of care: Rights and responsibilities, Charges for services, Pt/caregiver development of care plan, Complaint procedure, Goals of visits, Services provided, Discharge planning, EVV, Fire/safety/disaster emergency plan, Privacy notice, Instructions on measures to control infection, Advance directive

4. Med Profile

a. Medication compliance

○ Yes
○ No, see comment: _____

b. ☐ Medication reconciliation including, schedules and parameters documented in EMR, potential adverse effects, drug reactions, ineffective or duplicate drug therapy, and significant side effects, reviewed with patient/family.

5. Others

a. ☐ I confirm that I reviewed and entered all information and changes into the Others section of the EMR

b. • Flu Confirmed Date/Flu Declined Date and Flu Declined Comment

Mental Status

1. Please select all that apply:

☐ Oriented to person
☐ Oriented to situation
☐ Agitated
☐ Confused at times
☐ Oriented to place
☐ Disoriented
☐ Lethargic
☐ Other_____
☐ Oriented to time
☐ Forgetful
☐ Impaired cognitive/Decision making

Wellness and Immunizations

1. COVID Vaccine

a. COVID vaccine

- ○ Yes. Date of COVID vaccine ___ /___ /_____
- ○ No, educated

2. Pneumonia Vaccine

a. Pneumonia vaccine

- ○ Yes. Date of pneumonia vaccine ___ /___ /_____
- ○ No, educated

3. Colonoscopy

a. Colonoscopy

- ○ Yes. Date of colonoscopy ___ /___ /_____
- ○ No, educated
- ○ Not indicated

4. Mammogram

a. Mammogram

- ○ Yes. Date of mammogram ___ /___ /_____
- ○ No, educated
- ○ N/A, Male
- ○ Not indicated

5. Vision Testing

a. Vision testing

- ○ Yes. Date of vision test ___ /___ /_____
- ○ No, educated

6. Health screening additional information

_____

7. History of current substance use

a. History of, or current recreational drug use:
   - ○ Yes. Please Explain: _____
   - ○ No

b. History of, or current alcohol use:
   - ○ Yes. Please Explain: _____
   - ○ No

c. History of, or current smoker:
   - ○ Yes. Please Explain: _____
   - ○ No

Vital Signs

1. Temperature

a. Temperature (°F)

_____

b. Route

○ Oral ○ Axillary ○ Tympanic ○ Temporal

2. Blood Pressure (Systolic/Diastolic):

a. Systolic (mmHg)

_____

b. Diastolic (mmHg)

_____

3. Respiration Rate:

a. Respiration rate (breaths per minute)

_____

4. Pulse:

a. Pulse (beats per minute)

_____

5. Does the patient report any usual and/or present pain?

○ Yes. (Complete '#6. Pain' section below.) ○ No. (Skip '#6. Pain')

6. Pain

a. Usual pain intensity

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

b. Present pain intensity

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

c. Pain location

_____

d. Pain frequency

○ Daily ○ In the last week ○ Less than every week

e. Pain description

_____

f. Intervention

_____

g. Effectiveness of intervention
○ Yes
○ No. See comment: _____

i. Need for palliative care?
○ Yes, refer ○ No

7. Additional comments on pain if applicable

_____

8. Weight

a. Weight (lbs)

_____

b. ○ Actual ○ Reported

9. Height

a. Height (feet and inches)

_____

b. ○ Actual ○ Reported

Functional Limitations/Activities/Falls/Safety

1. Functional Limitations

a. Functional Limitations

☐ Ambulation ☐ Amputation ☐ Bedbound
☐ Bladder Incontinence ☐ Bowel Incontinence ☐ Cognition/Decision Making
☐ Contracture ☐ Dyspnea with minimal exertion ☐ Endurance
☐ Legally Blind ☐ Legally Deaf ☐ Paralysis
☐ Speech ☐ Other _____

2. Activities Permitted

a. Activities Permitted:

☐ Active Range of Motion ☐ Cane ☐ Exercise prescribed
☐ Transfer Bed/Chair ☐ Up as tolerated ☐ Walker
☐ Wheelchair ☐ Other _____

3. Fall Screen

a. Ambulation status

○ steady without device ○ Steady with device ○ Unsteady

b. Does the patient report any falls?

○ Yes. Falls occurred: ☐ Within the last 3 months ☐ Within the last 6 months

Education Provided: _____

Comments: _____

○ No

4. Safety Measures

a. List safety measures/precautions:

☐ Aspiration precautions ☐ Bleeding precautions ☐ Emergency plan developed
☐ Fall precautions ☐ Keep pathways clear ☐ Oxygen precautions
☐ Proper position during meals ☐ Seizure precautions ☐ Sharps precautions
☐ Slow position change ☐ Standard precautions/Infection ☐ Support during transfer/ambulation
☐ Use of assistive devices ☐ Other _____

Living Arrangements/Informal Support

1. Living arrangements

a. Home type:

○ Private house	○ Apartment	○ Senior citizen housing
○ Family care program	○ Foster home	○ Shelter
○ Other _____		

b. Home access:

○ Ground floor	○ Multi level - elevator	○ Multi level – no elevator

2. Patient lives with:

☐ Alone

☐ Spouse

☐ Family. Name: _____ Relationship to patient: _____

☐ Other. Name: _____ Relationship to patient: _____

3. Is patient self-directing?

○ Yes

○ No. **Is the individual who makes decisions on behalf of the patient an individual listed above who also lives with the patient?**

○ Yes, same as above

○ No. Name: _____ Telephone: _____

Relationship to patient: _____

4. Which informal caregiver is identified to provide support when the aide is not there or calls out?

○ As listed above, individual living with the patient

○ As listed above, individual responsible for making decisions on behalf of the patient

○ Other informal caregiver. Name: _____ Telephone: _____

Relationship to patient: _____

○ N/A

5. Can the patient be left alone safely?

○ Yes

○ No. See comment: _____

6. Please select who is responsible for the following tasks for the patient

	Self	Spouse	Family	Friend	Agency	N/A
Medication management	☐	☐	☐	☐	☐	☐
Vital signs	☐	☐	☐	☐	☐	☐
Treatment/wound care	☐	☐	☐	☐	☐	☐
Competence verified (teach back and/or demonstrated)	☐	☐	☐	☐	☐	☐

7. Is the contact information for the family/friend performing the tasks in the table already provided above?

○ Yes

○ No. Name:_____ Contact information: _____

Relationship:_____

○ N/A, all care provided by patient or spouse

8. If competence is not verified by teach back and/or demonstration, please comment below:

_____

9. Name and contact information if an agency is providing skilled services

Name:_____ Contact information: _____

10. Are hours and services appropriate and at a safe level for the patient?

○ Yes

○ No, call the agency and comment: _____

11. Additional information needed?

○ Yes: _____

○ No

DME and Supplies

1. Does the patient use DME and Supplies?

○ Yes, see below ○ No (Skip '#2. DME and Supplies & #3')

2. DME and Supplies

☐ Bedside commode
☐ Diabetic supplies
☐ Gait belt
☐ Hospital bed
☐ Incontinence supplies
☐ Oxygen
☐ Tub/shower bench
☐ Walker
☐ Other _____
☐ BIPAP
☐ Dressing supplies
☐ Glucometer
☐ Hoyer -1 person assist
☐ Nebulizer
☐ PERS/Lifeline
☐ Tub/shower rails
☐ Wheelchair
☐ Cane
☐ Feeding pump
☐ Grab bars
☐ Hoyer -2 person assist
☐ Ostomy supplies
☐ Raised toilet seat
☐ Urinary catheter supplies
☐ Wound care supplies

3. DME is safe, appropriate, in good working order and patient family caregiver knowledgeable in use

○ Yes

○ No, supervisor notified. See comment:_____

Neuro

1. Neurological

Vision

1. Vision

Hearing

1. Hearing

Musculoskeletal

1. Musculoskeletal

Integumentary

1. Skin has normal turgor and is intact?

○ Yes

○ No, poor skin turgor. Comment:_____ (skip '#2 Wound Care & #3 Wound Info')

○ No, patient has wounds, see Wound Care and Wound Information below:

2. Wound Care

a. Party responsible for wound care and contact information

_____

b. Frequency of dressing changes

_____

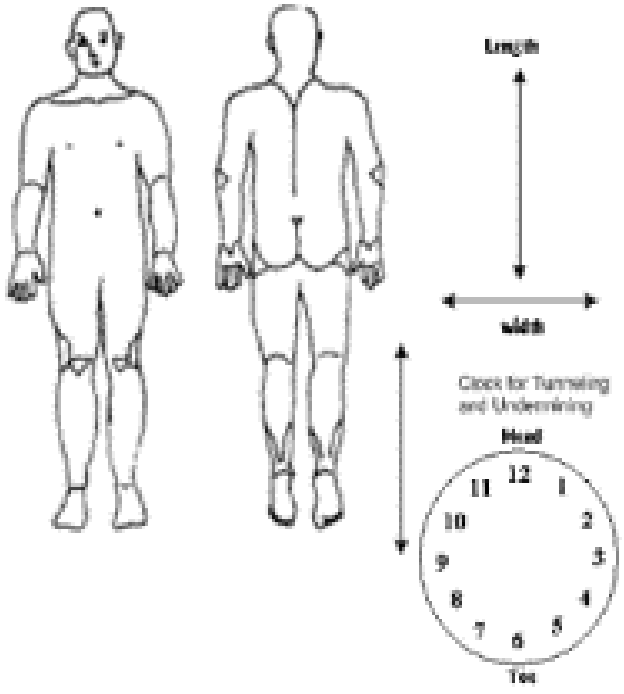
c. Refer to MD/MLTC

○ Yes ○ No

d. Additional comments

_____

f. Wound reference:



Tunneling Description

Pathway that extends from wound surface and tunnels in one or more directions, places patient at risk for abscess formation. Example: 3 cm depth at 6 o'clock

Undermining Description

Tissue destruction underneath intact skin along wound margin (terminology used to replace lip/shelf). Example: 1 cm noted from 9-11 o'clock

Exudate Description

Serous-thin, water, clear

Serosanguinous-thin, watery, pale red to pink

Sanguinous-thin, bright red

Purulent-thin or thick, opaque tan to yellow

Skin Lesions Includes:

Wounds, rashes, bruises, sores, cellulitis, ecchymosis, redness without break in skin

Arterial and diabetic ulcers

Healed stage 2 pressure ulcers with scar, healed stage 3 & 4 pressure ulcers

Skin Tears

Burns

Surgical incision, pin sites, wounds with staples or sutures

Tracheostomy, thoracostomy, urostomy (If the Home Health Agency is providing clinical interventions)

PICC line, Central Line, Portacath, Mediport, implantable infusion devices, venous access devices

Peripheral IV site

Current surgical wound or healed scar f pacemaker insertion

All alterations in skin integrity are considered to be lesions

Excludes: Bowel ostomies

3. Wound Information (list each separately)

a. Location

_____

b. Description

_____

c. Measurement in cm (Length X Width X Depth)

_____

d. Drainage

_____

e. Condition surrounding skin

_____

(Repeat Wound Information a – e for each additional wound below)

_____
_____
_____
_____
_____
_____

4. Does the patient have ostomies?

○ Yes. Type of ostomy: _____

Condition of surrounding skin: _____

○ No

Respiratory

1. Respiratory

Cardiovascular

1. Does the patient have the following:

a. Edema

○ Yes ○ No

b. Pacemaker

○ Yes ○ No

c. Palpitations

○ Yes ○ No

d. Anticoagulants

○ Yes ○ No

2. Comments

_____

Endocrine

1. Is the patient diabetic?

○ Yes. - Insulin taken per MD order? ○ Yes

○ No, see comment: _____

○ N/A, patient is not insulin dependent

- Does the patient monitor their blood glucose? ○ Yes, as per their MD.

Blood glucose ranges AM: _____

Blood glucose ranges PM: _____

○ No, as per their MD

○ No

2. Endocrine Comments

_____

Gastrointestinal

1. Bowel sounds

○ Yes ○ No, see comment below

2. Last B/M

_____

3. Continent of bowel

○ Yes ○ No, see comment below

4. Comments

_____

5. Does the patient have gastrointestinal ostomies

○ Yes. Type of gastrointestinal ostomy: _____

Care required: _____

Responsible party: _____

○ No

Genitourinary

1. Genitourinary

a. Urinary elimination

_____

b. Continent of urine?

○ Yes

○ No. When does urinary incontinence occur?

☐ Timed-voiding defers incontinence ☐ During night only ☐ During the day and night

c. Urinary catheter/ostomies?

○ Yes. Urinary catheter type: ○ Condom
○ Straight
○ Indwelling- French size: _____
Ballon size: _____
Frequency of change: _____
Responsible party: _____

○ No

d. Other ostomies?

○ Yes. Type: _____
Care required: _____
Responsible party: _____

○ No

Nutrition

1. Food Provision. Check all that apply:

☐ Food in the house
☐ Family shops for patient
☐ N/A, G-tube
☐ Not enough food in the house
☐ Aide shops for patient
☐ Other_____
☐ Meals On Wheels delivers
☐ Supermarket delivers groceries

2. Nutrition Risk/Intervention

a. Nutrition risk/Intervention

○ High Risk: Impaired or inadequate food and fluid intake/difficulty chewing or swallowing
○ Moderate Risk: Issues with availability of food and fluid for patient
○ Low Risk: Comorbidity, multiple medications, dentures

b. Intervention:

☐ Refer to MD (MLTC) evaluation
☐ Refer to APS/proxy/Nurse manager
☐ Education provided

c. Comment on intervention below:

_____

3. Diet

a. Choose the (one) diet that is most appropriate

Please select only ONE diet.

☐ Low fat diet ☐ Low salt diet ☐ No concentrated sweets, no added sugar

☐ Regular diet ☐ Other_____

☐ N/A, G-tube. Feeding orders: _____

Responsible party: _____

Psychosocial

1. PHQ-2

a. Over the last two weeks, how often have you been bothered by any of the following problems?

If you score a 3 or greater, please move on to the next question, the PHQ-9. If you scored a 2 or below, you may skip the PHQ-9.

	Patient unable to communicate response (Score: 0)	Not at all (Score: 0)	Several days (Score: 1)	More than half of the days (Score: 2)	Nearly every day (Score: 3)
1. Little interest or pleasure in doing things	○	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○	○

Total Grid Score (sum) _____

b. Is the PHQ-2 "Total Grid Score (sum)" a 3 or greater?

○ Yes, complete PHQ-9 below ○ No (skip '#2 PHQ-9')

2. PHQ-9

a. Over the last two weeks, how often have you been bothered by any of the following problems?

To be completed if the patient scored a 3 or greater on the previous question, the PHQ-2.

	Not at all (Score: 0)	Several days (Score: 1)	More than half of the days (Score: 2)	Nearly every day (Score: 3)
3. Trouble falling asleep, staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○

6. Feeling badly about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	○	○	○	○
7. Trouble concentrating on activities like reading the newspaper or watching TV	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thinking that you would be better off dead or that you wanted to hurt yourself in some way	○	○	○	○

Total Gride Score (sum) _____

b. PHQ-2 and PHQ-9 Scoring

Total the points associated with each patient answer and take appropriate action according to the patient's total score.

Implement the action that correlates with the patient's total score. Document your actions in the nursing progress notes.

Score 0-4 Points: **None**

Action: Repeat PHQ-9 At Reassessment.

Score 5-9 Points: **Mild Depression**

Action: Notify Physician, Assess Patient For Worsening Depression At Each Visit, Repeat PHQ-9 At Reassessment, Refer MSW And Or Other Community Resources.

Score 10-14 Points: **Moderate Depression**

Action: Physician Notification, Assess Patient for Worsening Depression At Each Visit And Report To MD, Assess Effectiveness Of Current Treatment Plan Including Counseling And Medications, Assess Need For Mobile Crisis And Refer As Needed, Repeat PHQ-9 At Reassessment.

Score 15-19 Points: **Moderately Severe Depression**

Action: Physician Notification, Assess Patient For Worsening Depression At Each Visit, Assess Effectiveness Of Current Treatment Plan Including Counseling And Medications And Report To MD, Assess Need For Mobile Crisis, 911.

Score 20-27 Points**: Severe Depression**

Action: NOTIFY PHYSICAN, call 911

Alert: A yes response to #9 or suicide threat regardless of the total score would trigger a Severe Depression severity category response.

c. Is the combined score of the PHQ2 and PHQ9 greater than or equal to 5?

○ Yes. ☐ Score reported to clinical Supervisor ☐ Reporting interviewed with caregiver, when to notify agency and EMS of signs of depression. ☐ Patient and/or caregiver instructed to follow up with MD

○ No

3. Do you (patient) feel more lonely or isolated than usual?

○ Yes, educated provided: _____

○ No

4. Abuse, mistreatment, and neglect screen:

○ Signs absent

○ Signs present; supervisor notified: _____

Intervention: ☐ APS/Social work referral ☐ MD notified ☐ MCO notified
☐ Abuse hotline number provided or called ☐ 911 called

ADL/Functional Assessment

1.

	Independent	Requires assistance or supervision	Totally dependent
1. Grooming	○	○	○
2. Dressing	○	○	○
3. Bathing	○	○	○
4. Toileting	○	○	○
5. Transferring	○	○	○
6. Feeding or Eating	○	○	○
7. Planning/Preparing Light Meals	○	○	○
8. Laundry	○	○	○
9. Housekeeping	○	○	○
10. Shopping	○	○	○

2. Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

○ Able to walk alone with or without assistive device or able to wheel self

○ Requires assistance to walk or wheel a chair

○ Non-ambulatory

Environmental Safety Assessment

1. Environmental Safety

KEY: Yes=Safe, No=Unsafe, N/A=Not applicable to this patient or environment

	Yes	No	N/A
Clean	○	○	○
Uncluttered walking path	○	○	○
Heat	○	○	○
Air-conditioning	○	○	○
Adequate lighting	○	○	○
Adequate night lights	○	○	○
Lights easily reached	○	○	○
Adequate electricity	○	○	○
Visible electrical cords un-frayed	○	○	○
Visible outlets not overloaded	○	○	○
Outlets properly accessed	○	○	○
Electric cords along walls	○	○	○
Storage at waist to eye level	○	○	○
Unbuckled carpets	○	○	○
Scatter rugs with non-stick backs	○	○	○
Non-skid treads on steps	○	○	○
Stairs with hand rail	○	○	○
Adequate furnishings	○	○	○
Wheeled furniture has locks enabled	○	○	○
Furniture without sharp edges	○	○	○
Adequate storage space	○	○	○
Flushing toilet	○	○	○
Toilet seat proper level	○	○	○
Tub/shower	○	○	○
Handgrips in tub/shower	○	○	○
Seat in tub/shower	○	○	○
Refrigerator	○	○	○
Stove	○	○	○
Phone easily accessible	○	○	○
Posted emergency numbers	○	○	○
Lifeline/PERS	○	○	○
Fire evacuation plan	○	○	○
Disaster evacuation plan	○	○	○
Hazardous waste disposal	○	○	○
Medications safely stored/labeled	○	○	○
Fire escape/second exit	○	○	○
Fire extinguisher present	○	○	○
Pets in home	○	○	○
Other	○	○	○

2. Please list “Other” if yes above

_____

3. Safety assessment comments

_____
_____
_____
_____
_____

Prognosis/Rehab Potential/Goals

1. Prognosis

Please select only ONE

☐ Poor ☐ Guarded ☐ Fair
☐ Good

2. Rehab Potential

○ Poor - Improvement in functional statis is not expected; decline is probable

○ Fair - Minimal improvement in functional statis is expected; decline is possible

○ Good - Improvement is functional status is expected

3. Goals

a. Patient will:

☐ Remain safe in the community

☐ Comply with his/her diet and medication regimen

☐ Not be hospitalized during this assessment period

☐ Other _____

b. Discharge Plan:

☐ At request of patient or vendor

☐ To another agency or level of care when this agency can no longer care for the client

Services and Frequency

1. Nurse

○ Every 3 months aide supervision and every 6 months RN reassessment or PRN as needed

○ Every 6 months aide supervision and every 6 months RN reassessment or PRN as needed

○Other_____

2. Aide discipline

○ HHA ○ PCA

3. Aide Frequency and Duration

a.

Hours/Day	Days/Week
_____	_____

(If there are additional frequencies please list in the same format)

Progress Note

1. Progress note

Signatures

Please review:

1. ☐ I have participated and agreed with the plan of care developed together with my nurse, and received a copy that will remain in my home.

2. ☐ I have seen and understand the EVV Fact Sheet What You Should Know About Electronic Visit Verification (EVV) posted on the Department's EVV website: EVV Fact Sheet for Medicaid Beneficiaries and Families.

3. ☐ I attest that the visit with an RN took place on the date listed

4. Patient Signature

X_____ **OR** ☐ Patient is unable to sign. Authorized agent signing on the patient's behalf:

Reason that patient is unable to sign

_____

Authorized agent signature

X_____

Print name:

_____

Relationship to patient:

_____

5. RN Signature

X_____