NURSING ASSESSMENT/MONITORING FOR

Living Choice **Medically Fragile**

Participant Name:			**SoonerCare ID #:**
DOB:	**Phone:**	**Time in:**	**Time out:**
Nurse completing document: (please print)		**Agency:**	**Date:**
Transition Coordinator & TC agency:			**Date copy sent to TC:**

Visit Type
- ☐ Initial nurse evaluation, IDT (complete pages 1, 2, & 3)
- ☐ Reassessment, IDT (complete pages 1, 2, 3, & 4)
- ☐ 6 month evaluation (complete pages 1, 2, 3, & 4)
- ☐ ASR supervision (complete pages 1, 2, & 4)
- ☐ Skilled nurse visit (complete box below) (complete pages 1 & 2)

Reason for SN visit (check all that apply): ☐fill med box ☐foot care ☐wound care ☐catheter change ☐lab draw ☐other:

Diagnoses: ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ COPD ☐Other

Visit to any of the following in the past 6 months? *Check all that apply*

☐Hospital	☐Emergency room	☐Nursing Facility	☐Behavioral health facility
Date(s): ____________	Date(s): ____________	Date(s): ____________	Date(s): ____________
Comments: ____________	Comments: ____________	Comments: ____________	Comments: ____________

Physicians / Health Practitioners

Practitioner Name	**Specialty**	**Date last seen**	**Phone**

ASSESSMENT

VS	**BP:** _____/ _____	**Pulse:** _____	**Respirations:** _____	**Height:** _____	**Weight:** _____

Neurological:

Mental/Behavioral Health:

Integument:

Cardio/Pulmonary:

Nutrition:

Elimination:

Mobility:

Sleep:

Pain:

Details specific to Participant's current chronic health condition(s):

Equipment/Supplies Participant is Currently Using: ☐**Cane** ☐**Wheelchair** ☐**Walker** ☐**Glasses**
☐**Shower Chair** ☐ **Hand Held Shower** ☐ **Grab Bars** ☐**BSC** ☐**Incontinent Supplies** ☐ **Hearing Aid**
☐**Other:** ____________________

Details of skilled care provided:

Participant's response to care:

Medications

Name of Medication	Dose	Route	Frequency	Purpose	Date Filled	Physician

Allergies

Pharmacy Information
Name: _____
Phone: _____

Medication Information
Medication administered by: ☐Self ☐Family/friend/other (list name and relationship): _____
Uses med planner: ☐Yes ☐No If yes, filled by: _____

Signatures *(If Participant signs with a mark, two witnesses are required.)*

Participant or Legal Agent	*Date*______	*Witness*	*Date*______
Nurse completing document	*Date*______	*Witness*	*Date*______

Needs Assessment Summary

Participant Name:	**SoonerCare ID #:**

Needs Assistance With

*KEY

Who: S = Self P = PCA I = Informal O = Other **Freq:** How often is assistance needed?
PCA hrs/wk: If PCA performs or assists w/ task, designate the amount of time needed in this column.

ADL's				**IADL's**			
Task	Who*	Freq*	PCA hrs/wk*	Task	Who*	*Freq	PCA hrs/wk*
Dressing				**Shopping/Errands**			
Bathing				**Cooking/Meal Prep**			
Grooming				**Housekeeping**			
Toileting				**Laundry**			
Eating				**Money Management**			
Mobility/Transfer				**Telephone**			
Standby Assist				**Heavy Chores**			
				Medication Assist			
				Transportation			

Respite	**Hours/wk**
Respite provided by:_____ Comments: _____	

Advanced Supportive Restorative (ASR) Tasks	**Hours/wk**
☐ Transfers ☐ Specialty Lift ☐ Catheter Care ☐ Ostomy Care ☐ Range of Motion ☐ Bowel Program ☐Other: _____	

Safety Concerns

How long can Participant be home alone? ☐ Unlimited ☐ Short Periods ☐ Requires 24/7 supervision
(If "Unlimited" is not checked, please explain why in the comment box)

☐No concerns ☐Health status ☐Recent fall ☐Change in supports ☐Environment ☐Finances ☐Change in mental status
☐Unintentional weight loss ☐Equipment needs ☐Unmet supervision needs ☐Active APS case
☐Other: _____

Comments:

Current Other Agency Involvement:

☐Yes ☐No If yes, list name, service provided and contact information
_____

Resources

☐Medicare ☐Private Health Insurance: _____ ☐State Plan	☐Veterans Benefits ☐Vocational Rehabilitation ☐Hospice: _____	☐Private Pay ☐Community Organization: _____	☐Indian Health Services ☐Independent Living Center ☐Other: _____

Comments:

Recommendations

☐ Adult Day Health ☐ Respite ☐ Home Delivered Meals ☐ Hospice
☐ 24 hr. Supervision ☐ Mental Health Referral ☐ Nutritional Supplements ☐ Skilled Nursing
☐ ASR SN Monitoring ☐ Dietitian ☐ PERS ☐ Therapy ☐OT ☐PT ☐ST
☐ Environmental Modification(s):(Describe) _____ ☐ Other: _____

Comments:

Equipment &/or Supplies Needed:

Signatures *(If Participant signs with a mark, two witnesses are required.)*

Participant or Legal Agent	*Date* _____	*Witness*	*Date* _____
Nurse completing document	*Date* _____	*Witness*	*Date* _____
Transition Coordination (only applicable to IDT meetings)	*Date* _____		

PCA/ASR Supervisory Visit Report

Participant Name:	**SoonerCare ID #:**

Name(s) of current worker(s) and relationship to Participant: _____

PCA/ASR present at time of visit? ☐**Yes** ☐**No**
Amount of time allotted for PCA tasks: _____ **Amount being delivered:** _____
Amount of time allotted for ASR tasks: _____ **Amount being delivered:** _____

Assigned Task(s):

☐Bed Bath	☐Hair Care	☐Dusting	☐Vacuuming	☐Clean Kitchen	☐Bed Making
☐Tub Bath	☐Skin Care	☐Sweeping	☐Meal Prep	☐Dishes	☐Laundry
☐Shower	☐Standby Assist	☐Mopping	☐Clean Bathroom	☐Trash Removal	☐Advanced Meal Prep
☐Shampoo	☐Errands	☐Other: _____			

Advanced Supportive Restorative Task(s):

☐Transfers ☐Specialty Lift ☐Catheter Care ☐Ostomy Care ☐Range of Motion ☐Bowel Program
☐Other: _____

Details of ASR task(s) performed: _____

Are PCA/ASR's current skills adequate to perform tasks? ☐ Yes ☐ No (specify) _____

Questions for the Participant &/or Responsible Party

Are the above tasks performed to your satisfaction? ☐Yes ☐No ☐Sometimes
Comment: _____

Does the aide stay the entire time allotted? ☐Yes ☐No ☐Sometimes
Comment: ___

Are you contacted if the aide is unable to come at the scheduled time? ☐Yes ☐No ☐Sometimes
Comment: ___

Do you feel respected by the aide? ☐Yes ☐No ☐Sometimes
Comment: ___

Who do you contact if the aide does not show up? ___

Does the agency offer to send a replacement aide? ☐Yes ☐No ☐Sometimes
Comment: ___

Who fills in if a replacement aide is not available? ___

Is the current plan meeting your needs? ☐Yes ☐No
Comment: ___

Nurse's Recommendations

☐ **No Changes** ☐ **Increase Services** ☐ **Decrease Services**
Justification:

Signatures *(If Participant signs with a mark, two witnesses are required.)*

Participant or Legal Agent	*Date* ______	*Witness*	*Date* ______
Nurse completing document	*Date* ______	*Witness*	*Date* ______
Nurse Supervisor (if applicable)	*Date* ______		