Vicenza Home Health Care Services, Inc

4136 Oak Hill Avenue Nottingham, Maryland 21236

Phone 410-882-0568 Fax 410-882-7050

www.vicenzahomehealthcare.com

Nursing Assessment

Patient Name: ______________________________

Initial Assessment: ______ Date:_____/_____/_____

Monthly Assessment______

Diagnosis____

Circle or check all that apply. Add descriptive comments as needed. Indicate N/A (not applicable or does not apply) when appropriate.

SECTION 1: ENVIRONMENTAL ASSESSMENT

Neighborhood:

_______ Unclean/unkempt ___________ Safety Hazards ___________ Pests

_______ Accessibility to grocery/drug store, health care facilities, fire, police, ambulance

COMMENTS:

____

Home: General description of safety hazards, appearance, etc.: ________________

____

____

____

SECTION 2: PHYSIOLOGICAL SYSTEMS REVIEW

BP _____ P _____ R _____ T _____ WT _____ HT _____

A. General appraisal of appearance:_____________________________________

____

____

B. Assess level of consciousness/orientation: ______________________

C. Observe head and face (eyes, nose, lips): ______________________

______ c/o headaches ______ swelling/masses ______ pain/stiffness

______ hair loss ______ parasites ______ enlarged nodes/glands

______ PERRA ______ ears pinna symmetrical/no discharge

______ visual disturbance ______ strabismus ______ cataracts

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______ infection ______ contacts/glasses ______ glaucoma
______ ear infections ______ hearing aid ______ last audio exam

COMMENTS:

____

D. SKIN:

______ color ______texture ______ skin tumor ______lesions
______ itching/priritus ______ skin breakdown/redness

Pressure Ulcer Stages	Number of Pressure Ulcers				
Stage 1: Redness of intact skin; warmth, edema, hardness, or discolored skin may be indicators	0	1	2	3	4 or more
Stage 2: Partial thickness skin loss of epidermis and/or dermis. The ulcer is superficial and appears as an abrasion, blister, or shallow crater.	0	0	0	0	0
Stage 3: Full thickness skin loss; damage or necrosis of subcutaneous tissue; deep crater	0	0	0	0	0
Stage 4: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures	0	0	0	0	0
Location of ulcers: non					

COMMENTS:

____
____
____
____

E. NERVOUS SYSTEM

______ seizures ______ hallucinations ______ speech/language difficulties
______ gait problem ______ balance problem ______ learning disorder
______ tremor ______spasm ______ paralysis ______ memory loss

COMMENTS:

____
____
____
____

F. MUSCULOSKELETAL SYSTEM

______ joint swelling/red/pain _____ c/o back pain _____ twitching
______ weakness ______ difficulty with walking, bending, etc.

COMMENTS

G. RESPIRATORY SYSTEM

______ asthma ______ smoking _____ pneumonia/bronchitis
______ chronic cough breath sounds: ____ R ____ L ______a noisy breathing

COMMENTS:

H. CARDIOVASCULAR SYSTEM

______ apical rate ______ edema ______ irregular pulse

COMMENTS:

I GASTROINTESTINAL SYSTEM

______ bowel sounds present ______ tenderness of abdomen
______ c/o stomach pain/burning ______ pain w/eating ______ nausea/vomiting
______ c/o stomach pain/burning ______ blood noted in stool
______ non-distended/soft in all 4 quads

COMMENTS:

J. ELIMINATION

______ constipation ______ diarrhea ______ incontinent of urine
______ incontinent of stool ______ hx. Of UTI

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______ toileting schedule comments:

K. GYNECOLOGICAL:
______ regular menses ______ last period date ______ date of breast exam

COMMENTS:

____
____
____
____
____

M. OTHER HEALTH PROBLEMS/CONCERNS:

____

SECTION 3: CURRENT MEDICATIONS

Medication	Dose	Freq	Purpose	Comment

____

Attach additional pages if necessary

SECTION 4: Notes:

____
____
____
____
____
____
____
____

SECTION 5: ADDITIONAL RECOMMENDATIONS FOR FOLLOW-UP:

____
____
____
____
____

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Section: 6 Incident Tracking

Incident(s) Check/enter all that apply
Emergency Room Visit : ☐ Hospitalization : ☐ Death: ☐ Suicide: ☐ other: ☐
Accident/Injury: ☐ Fall ☐ Fracture ☐ Burn ☐ Laceration/wound ☐ Other
Abuse: Physical: ☐ Sexual: ☐ Verbal: ☐ Emotional: ☐ Neglect: ☐ Other: ☐

Section 7:MARYLAND ADVANCE DIRECTIVE

1. Do you have Advance Directive Yes ☐ No ☐
2. What is the name of your Primary Doctor? ____________
3. Who is your power of attorney? ____________

____
PRINT NAME OF NURSE :

____________ ____________
SIGNATURE OF NURSE DATE

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Client Plan Of Care Form

Instruction: This form must be completed for each new client or for existing clients when there is a change in his/her condition and/or new doctor's order(s).

Plan of Care	Check Box	Comment
Personal hygiene (I.e. bathing, hair, oral, nail, and skin care)	☐	
Toileting (bladder, bowel, and bed pan routines; movement to/from bathroom	☐	
Dressing and changing clothes	☐	
Mobility and transfers	☐	
Eating and drinking	☐	
Medications	☐	
Light housekeeping (e.g. laundry)	☐	
Errands	☐	
Other (please specify)	☐	

Nurse's legal name (PLEASE PRINT)	Date
Nurse's signature:	Date