COMPREHENSIVE NURSING ASSESSMENT

Client Name: _____

Address: _____

Home Telephone: _____ **Emergency Phone:** _____

Birth Date: _____ **Age:** _____ **Weight:** _____

Vital Signs: BP: _____/_____ **Pulse:** _____ **R/Rate:** _____ **Temp:** _____ **Ht:** _____

Advance Directive: **Yes** _____ **No** _____ **DNR:** **Yes** _____ **No** _____

Physician: _____ **Telephone:** _____

Address: _____

Allergies

_____
_____
_____

Recent Medical and Psychiatric History

_____
_____
_____
_____
_____
_____
_____

Past Medical and Psychiatric History

_____
_____
_____

Surgeries

_____
_____
_____

Current Medications (prescribed and OTC)

_____
_____

Sensory

Vision	**□ Normal □Glasses □Contact Lenses** **Problems:**
Hearing	**□ Normal □Hearing Aids** **Problems:**

Neurological

□ PERRL Other:	
Eyes	**Open spontaneously? □ Yes □ No**
Oriented	**□ Person □ Place □ Time □ Confused □ Forgetful □ Incomprehensible**
No response, client indicates needs by	
Memory Deficits	
Sleeping Pattern	**Hours at Night _____ Naps during day _____ Hours _____**
Sleep Aides	**□ Yes □ No** **Explain:**

Skin

□ Intact □ Jaundice □ Rash □ Scar □ Abrasion □ Laceration □ Decubitus □ Burn □ Erythema □ Petechia	
Describe Findings	

Circulatory

History Of	**□ Arrhythmia □ Hypertension □ Hypotension**
Heart Rate	**□ Regular □ Irregular □ Apical Rate/Rhythm**
Skin	**□ Pink □ Cyanotic □ Pale □ Mottled □ Warm □ Cool □ Dry □ Diaphoretic □ Edema □ Pitting □ Non-pitting**
Other Findings	

Respiratory

Respirations	**□ Regular □ Irregular □ Labored □ Unlabored**
Breath Sounds	**Clear: □ R □ L Rales: □ R □ L Rhonchi: □ R □ L**
Other Findings	

Musculoskeletal

History	**□ Pain/Stiffness □ Arthritis □ Fractures**
Mobility	**□ Ambulatory □ Bedbound □ Wheelchair □ Other**
Transferring	**□ Independent □ Dependent**
Assistive Devices	
Range of Motion	**□ Full □ Limited** **Explain:**

Nutrition

Appetite	**□ Good □ Fair □ Poor Number of meals per day _____**
Diabetes	**□ Insulin Dependent □ Non-Insulin Dependent**
Glucose Monitor	**□ Yes, # of times per day _____ □ No**
Diet	**□ Regular □ Soft □ Pureed**
Meal	

Restrictions	
Meal Supplements	
Feeding	□ Feeds Self □ Partial Assist □ Full Assist
Mucous Membrane	□ Dry □ Moist
Other Findings	

Dental

Dentures	□ Full □ Partial □ Upper □ Lower
Hygiene	□ Good □ Fair □ Poor Explain:

Elimination

Bowel Function	□ Uses toilet/ BSC □ Incontinence Products □ Frequency _____ Bowel Sounds Present: □ Yes □ No
Bladder Function	□ Uses toilet/ BSC □ Incontinence Products
Changes Prods Independently	□ Yes □ No
Special Needs	

Gynecological

Last Menstrual Period	
Breast Appearance	

Genitalia

Appearance of skin, testicles/penis, genitalia/labia:	

Emotional / Mood / Communication Skills

Behavior	□ Calm □ Crying □ Talkative □ Anxious/ Agitated
Eye Contact	□ Yes □ No
Other Findings	

Overall Safety Assessment

Clean/Cluttered Area For Food Preparation	□ Yes □ No Explain
Presence/Absence of Throw Rugs	□ Yes □ No Explain
Medications Safely Stored	□ Yes □ No Explain
Handrails/Safety Bars Present in Bathroom	□ Yes □ No Explain
Clear/Cluttered Path For Mobility	□ Yes □ No Explain

IADLs

Shopping for personal items	**□ Yes □ No Explain**
Transportation	**□ Yes □ No Explain**
Using The Telephone	**□ Yes □ No Explain**
Laundry And Linen Changing	**□ Yes □ No Explain**
Light Housekeeping	**□ Yes □ No Explain**
Other (Reading, Mail, Bills, etc.)	**□ Yes □ No Explain**

Additional Information Relevant to Client's Routine Care

_____

_____

_____

MF/MC □ YES □ NO **CNA required** □ YES □ NO

□ **None** **Self-Administered Medications**

Drug	Dose	Time

Pertinent Diagnoses (to include cognitive ability and emotional stability)

_____

_____

_____

_____

Diet/Nutritional Needs

_____

_____

Medical Equipment Needs

_____

_____

Service Notes on Tasks (and specific direction if required)
_____
_____
_____
_____
_____

Special medication or treatments required

_____

See Medication List

_____

Time/Frequency _____ Duration of services _____

Day	From	To
□ Monday		
□ Tuesday		
□ Wednesday		
□ Thursday		
□ Friday		
□ Saturday		
□ Sunday		

Goals & Objectives
_____
_____
_____

RN (print) _____

Signature of RN _____ Date _____

ADVANCE DIRECTIVE CHECKLIST

Please read the following statements. After reading the statements, please write your initials at the end of **each** statement.

1. I have been given written materials on my rights to accept or refuse medical treatment and/or services and on my rights to formulate Advance Directives.

_____ (Client's initials)

2. I understand that I am not required to have an Advance Directive in order to receive services or medical treatment from _____Favored Healthcare Services_____.
(Service Provider)

_____ (Client's initials)

3. I desire that the terms of any Advance Directive that I execute will be followed by

_____Favored Healthcare Services _____.
(Service Provider)

_____ (Client's initials)

(over)

Please read the following statements. After reading the statements, please check **ONE** of the following statements:

4. _____ I have executed an Advance Directive and will provide a copy to the home and/or CCSP provider agency providing services. I understand that the staff of _____**FAVORED HealthCare SERVICES**_____ will not be able to follow the terms of my Advance Directive until I provide a copy of it to the staff.

5. _____ I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.

6. _____ I have not executed an Advance Directive but would like to obtain additional information about Advance Directives.

_____ _____
Client's Signature Date

_____ _____
Witness' Signature Date

MEDICATION LIST

Client **Pharmacy** **Number**

Allergies **Physician** **Number**

Date	Name of Medication	Dosage / Frequency	Reason for Medication