CAREPATHrx

Nursing Start of Care Assessment

Date of Service: **Time of Service:**

Patient Name: ______________________________

Patient DOB: ______________________________

Allergies: ______________________________

Surgical Procedure(s) Relevant to Care and Dates:

Principal Diagnosis(es): ______________________________
(Primary Reason for Service)

Other Secondary Diagnosis(es): ______________________________

Therapy & Reason/Dx: ______________________________

History of current illness:

Hospitalization Reason:

Admission Date:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Household Members: ☐ Lives alone with spouse ☐ Lives with significant other ☐ Lives with child ☐ Lives with other relative ☐ Lives with friend ☐ Lives in group home ☐ Pets in the home: Type: _______ Number: ______ ☐ Other living situation:

Primary Caregiver: ☐ Self ☐ Spouse ☐ Significant Other ☐ Child ☐ Other Relative ☐ Friend ☐ Other:

Caregiver Name: ______________________________

Phone Number: ______________________________

Other Support Person Name: ______________________________

Phone Number: ______________________________

Patient is:

☐ Cooperative and able to learn
☐ Cooperative and requires additional education
☐ Cooperative and unable to learn
☐ Uncooperative with learning/self-care
☐ Alert ☐ Oriented x3 ☐ Impaired Orientation
☐ Other: ______________________________

Comments:

Caregiver is:

☐ Cooperative, available and willing to learn
☐ Cooperative, limited availability and willing to learn
☐ Uncooperative, available, and resistant to learn
☐ Uncooperative, limited availability and resistant to learn
☐ Other: ______________________________

Comments:

Understanding:

Patient Understanding of Diagnosis:
☐ Good ☐ Fair ☐ Poor

Caregiver Understanding of Diagnosis:
☐ Good ☐ Fair ☐ Poor ☐ N/A

Activity Ordered:

☐ Complete bedrest
☐ Bedrest with BRP
☐ Bed to chair transfer
☐ Up as tolerated
☐ Non-Weight bearing
☐ Partial weight bearing
☐ No restrictions

Other/ Comments:

Assistive Devices:

☐ None- independent ambulation
☐ Cane ☐ Walker ☐ Crutches
☐ Wheelchair ☐ Motorized wheelchair

Other/ Comments:

Home Equipment/Supplies:

☐ Hospital bed
☐ Wound vac
☐ Suction
☐ Oxygen
☐ Dressing Care
☐ Catheter Care
☐ Ostomy Care
☐ IV supplies
☐ Venipuncture
☐ Tube Feeding
☐ Irrigation

Other/ Comments:

Functional Limitations:

☐ None
☐ Limited endurance
☐ Paralysis
☐ Legally blind
☐ Contracture
☐ Speech difficulty
☐ Deaf
☐ Hard of hearing
☐ Cognitive deficit
☐ Dyspnea with minor exertion
☐ Bowel/bladder incontinence

Other/ Comments:

Home Dwelling:

☐ Private home ☐ Group home
☐ Other: ______________________________
☐ Emergency number posted in home
☐ Functional utilities (electric, water & heat)
☐ Dedicated medication storage
☐ Sanitary living environment
☐ Household free of violence
☐ At risk of being evicted

Number of floors in home:

Safety Concerns:

☐ Fall risk
☐ Ambulation with assistance
☐ Active supervision
☐ Transfer with assistance
☐ Blood and body fluid
☐ Seizure precautions
☐ Needle precautions
☐ IV contamination risk (record below)

Other/ Comments:

Medical Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Guarded

Discharge Plans:

Patients' Rehabilitation potential to achieve goals:
☐ Excellent ☐ Good ☐ Fair

Patient will maintain optimum health and functional level:
☐ w/o agency assistance ☐ w/community support services ☐ w/ in home assistance

Agency: ______________________________
Contact: ______________ Phone:__________ Fax: __________
Services Provided: ______________________________

Agency: ______________________________
Contact: ______________ Phone:__________ Fax: __________
Services Provided: ______________________________

Nurse Name: ______________________________

Agency: ______________________________

Signature: ______________________________

Date: ______________________________