RECERTIFICATION COMPREHENSIVE ASSESSMENT

odate 485/POC locators per organizational guidelines				
CLINICAL RE	CORD ITEMS			
lealth Insurance Claim # (Locator #1)			/	
Certification Period (Locator #3)/ through/		,		
Primary Diagnosis		ICD Code (Locator	11)	
l		() Date	O/
Other Diagnosis		ICD Code (Locator	13)	
)		() Date	O/
k		() Date	O/
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Surgical Procedure		ICD Code (Locator	('	
	THE C) Date	
ζ\		() Date	O
ASSESSMENT AND OBSERV	VATION SIGNS	SYMPTOMS	1	
(Mark all applicable with an "X". Circle	appropriate iten	n(s) separated by "/".		
Reason for visit:				
rognosis (Locator #20) 🗆 1-Poor 🚨 2-Guarded 🗅 3-Fair 🗓 4-Good 🗅 5	-Excellent		N)	
ndicate any change to the following: Demographics Deayor Source	☐ Physician ☐	Advance Directives	Emergency Code	
□ Other Clist changes:				
	1 1			
Mark all applicable with an "X". Circle appropriate item(s) separated by "/".)				
1ental Status: (Locator #19) < □ No change □ Oriented □ Comatose □ F		ssed Disoriented	□ Lethargic	
☐ Agitated ☐ Other				
itals: Temperature	Rectal Pulse:	Radial	☐ Apical ☐ Brachial	
Respirations Regular D Irregular			Irregular	
Respirations □ Regular □ Irregular lood Pressure: Right/ Left/ □ Lyi				
/eight: □ Actual □ Reported □ Same □ Change signific	na 🗆 Sittina 🗅	Standing	_ inegular	
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Patient Name_ ID #_

GASTROINTESTINAL	IV			
□ No Problem □ Same	□ Not Applicable □ No Problem			
(Locator #16) Nutritional requirements (diet)	Type of line: ☐ Peripheral ☐ PICC ☐ Central (type)			
□ Anorexia □ Nausea/Vomiting □ Difficulty swallowing	☐ Implanted port Location (specify)			
□ Tube feeding (specify)	Site (if appropriate) Site (describe)			
□ Continuous □ Intermittent	Catheter lengthcm Arm circumferencecm			
Comments:	☐ No evidence of infection			
	☐ Dressing change performed by: ☐ Self ☐ Family/caregiver ☐ Nurse			
GENITOURINARY	☐ Other			
□ No Problem □ Same	☐ Cap change performed by: ☐ Self ☐ Family/caregiver ☐ Nurse			
☐ Burning ☐ Frequency/Urgency ☐ Retention/Hesitancy	☐ Other			
□ Odor □ Hematuria □ Incontinence	☐ Extension/tubing changed by: ☐ Self ☐ Family/caregiver ☐ Nurse			
☐ Catheter (specify) type FrenchmL/balloon	☐ Other			
Bulb inflatedmL ☐ Changed ☐ Inserted ☐ Removed	☐ Line flushedmL saline/sterile water			
Irrigated with (specify)	☐ Line flushedmL Heparinunits/mL			
Comments:	☐ Instructed patient/family/caregiver on infusion therapy			
	☐ Patient/family/caregiver demonstrates/verbalizes proper			
MEDICATION	management of infusion(s)			
	□ Lab: □ None □ Blood drawn fromfor			
(Locator #10) (New or changed since last visit)	Other Delivered to			
□ None □ Update Medication Profile □ Order obtained	ENTERAL FEEDINGS - ACCESS DEVICE			
□ Administered by: □ Self □ Family/caregiver □ Nurse □ Other				
□ Medication administered this visit	□ N/A □ No Problem □ Nasogastric □ Gastrostomy □ Jejunostomy			
Name Name	☐ Other (specify)			
Dose Route				
Instructed on:	Pump: (type/specify)			
☐ Medication(s) names (list)	Feedings: Delus Continuous			
□ S/S allergic reaction □ Pill count (if applicable)	Flush Protocol: (amt./specify)			
□ Drug/food interactions □ S/E contraindications				
□ Drug/drug interactions □ Ample supply				
□ Expiration dates □ Proper disposal of sharps	Performed by: ☐ Self ☐ RN ☐ Caregiver ☐ Other			
☐ Prescription refill by ☐ Duration of therapy	Dressing/Site care: (specify)			
☐ Missed doses/what to do ☐ Other				
Medication setup for				
☐ Prefill insulin syringes for days	Interventions/Instructions/Comments			
SKIN/WOUN	ND/OSTOMY			
□ No Problem	(Measure per organizational guidelines)			
☐ Wound care/dressing change performed by: ☐ Self ☐ Nurse	WOUND #1 #2 #3			
☐ Family/caregiver ☐ Other	Location			
☐ Soiled dressing removed/disposed of properly	Length			
☐ Wound cleaned (specify)				
☐ Wound irrigated (specify)	Width			
☐ Type of dressing(s) used	Depth			
☐ Wound debridement	Drainage			
☐ Drainage collection container emptied. Volume	Tunneling			
☐ Patient tolerated procedure well	Odor			
☐ Medicated prior to wound care	Stoma			
☐ Patient/family/caregiver instructed on wound care/ostomy/disposal of soiled dressing	Comments:			
☐ Patient/family/caregiver to perform wound care/ostomy/dressing change				

Patient Name ID# **FALL RISK REASSESSMENT FUNCTIONAL LIMITATIONS** (Locator #18A) 1. Any falls reported since last assessment? □ 1-Amputation □ 7-Ambulation □ No □ Yes (describe) □ 2-Bowel/Bladder ■ 8-Speech (Incontinence) □ 9-Legally blind □ 3-Contracture ☐ A-Dyspnea with minimal exertion ☐ 4-Hearing □ B-Other (specify) □ 5-Paralysis 2. Have fall risk factors changed since prior assessment? □ 6-Endurance □ No □ Yes (describe) ACTIVITIES PERMITTED (Locator #18B) ■ 8-Crutches □ 1-Complete bedrest □ 9-Cane ☐ 2-Bedrest/BRP 3. Complete the reassessment and score it when appropriate and ☐ A-Wheelchair ☐ 3-Up as tolerated according to organization guidelines. □ B-Walker ☐ 4-Transfer bed/chair Assess each factor and circle the score when "yes", then total the points. C-No restrictions □ 5-Exercises prescribed □ D-Other (specify) □ 6-Partial weight bearing **Patient Factors** ☐ 7-Independent in home History of falls (any in the past 3 months?) 15 Sensory deficit (vision and/or hearing) 5 ALLERGIES Age (over 65) 5 Allergies: (Locator #17) U None known U Aspirin Confusion 5 ☐ Penicillin ☐ Sulfa ☐ Pollen ☐ Eggs Impaired judgment 5 ☐ Milk products ☐ Insect bites Decreased level of cooperation 5 ☐ Other Increased anxiety/emotional liability 5 Unable to ambulate independently (needs to use ambulatory aide, 5 chairboard, etc.) AGE SPECIFIC GROWTH & DEVELOPMENT ASSESSMENT Gait/balance/coordination problems 5 Incontinence/urgency 5 □ No Problem □ Same Cardiovascular/respiratory disease affecting perfusion and/or 5 oxygenation Postural hypotension with dizziness 5 Medications affecting blood pressure or level of consciousness (consider antihistamines, antihypertensives, antiseizure, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics) Alcohol use 5 **Environmental Factors** Home safety issues (lighting, pathway, cord, tubing, floor coverings, 5 stairs, etc.) Lack of home modifications (bathroom, kitchen, stairs entries, etc.) 5 Total points: INTERVENTIONS/INSTRUCTIONS Implement fall precautions for a total score of 15 or greater. Analysis/Interventions/Instructions/Patient Response: 4. Organizational guidelines: a. Educate on fall prevention strategies specific to areas of risk b. Refer to Physical Therapy and/or Occupational Therapy c. Monitor areas of risk to reduce falls d. Reassess patient Safety Measures: (Locator #15) □ 1 - Bleeding precautions □ 8 - 24 hr. supervision ☐ 2 - O₂ precautions 9 - Clear pathways □ 3 - Seizure precautions □ 10 - Lock w/c with transfers □ 4 - Fall precautions □ 11 - Infection control measures ☐ 5 - Aspiration precautions ☐ 12 - Walker/cane

☐ 13 - Other_

6 - Siderails up7 - Elevate head of bed

Patient Name ID# **DME SUPPLIES** (Locator #14) IV SUPPLIES: URINARY/OSTOMY: DIABETIC: SUPPLIES/EQUIPMENT: ☐ IV start kit Underpads □ Chemstrips ☐ Bathbench WOUND CARE: □ IV pole ☐ External catheters □ Syringes ☐ Cane □ 2x2's ☐ IV tubina ☐ Urinary bag/pouch ☐ Commode □ Other ☐ 4x4's ☐ Ostomy pouch (brand, size) ☐ Alcohol swabs ☐ Special mattress overlay ☐ ABD's ☐ Angiocatheter size ☐ Cotton tipped applicators ☐ Ostomy wafer (brand, size) □ Tape ☐ Pressure relieving device ■ Wound cleanser MISCELLANEOUS: ☐ Extension tubings ■ Wound gel ☐ Stoma adhesive tape ☐ Injection caps □ Fnema supplies □ Eggcrate ☐ Drain sponges ☐ Central line dressing ☐ Skin protectant ☐ Feeding tube: ☐ Hospital bed ☐ Gloves: ☐ Other ☐ Infusion pump type____ size size ☐ Hoyer lift □ Sterile □ Non-sterile □ Batteries size ☐ Enteral feeding pump ☐ Hydrocolloids ☐ Staple removal kit □ Syringes size □ Nebulizer ☐ Kerlix size FOLEY SUPPLIES: □ Other ☐ Steri strips □ Oxygen concentrator □ Nu-gauze _Fr catheter kit □ Other ☐ Suction machine ☐ Saline (tray, bag, foley) □ Ventilator □ Tape ☐ Straight catheter ■ Walker ☐ Transparent dressings ☐ Irrigation tray ■ Wheelchair ☐ Other □ Saline ☐ Tens unit □ Acetic acid □ Other ☐ Other PROFESSIONAL SERVICES Locator #21 Complete this section only when 485/POC is completed FLUSHING PROTOCOL/ ☐ Evaluate Wound/Decub for Healings Emergency Code: _ FREQUENCY (specify) Check and specify patient ☐ Measure Wound(s) Weekly specific orders for POC □ Administer Flush(es) ☐ Teach Wound Care/Dressing □ DNR - Do Not Resuscitate mL normal saline ☐ Other (must have MD order) ELIMINATION SN - FREQUENCY/DURATION_ mL normal saline Folev French inflated balloon □ Skilled Observation for mL changed every with mL sterile water ☐ Suprapubic Cath Insertion every_ ☐ Evaluate Cardiopulmonary Status ☐ Teach Care of Indwelling Catheter ☐ Evaluate Nutrition/Hydration/Elimination mL heparin unit/mL ☐ Teach Self - Cath ☐ Evaluate for S/S of Infections ☐ Teach Ostomy Care ☐ Teach Disease Process mL heparin unit/mL ☐ Teach Bowel Regime ☐ Teach S/S of Infection and Standard Precautions □ Other ☐ Teach Diet **GASTROINTESTINAL** ☐ Teach Home Safety/Falls Prevention ☐ Teach S/S of IV Complications ☐ Teach N/G Tube Feeding □ Other ☐ Teach IV Site Care Teach G-Tube Feeding ☐ PRN Visits for_ ☐ Teach Infusion Pump Other □ Psychiatric Nursing for_ ☐ Teach Complete Parenteral Nutrition **DIABETES MEDICATIONS** ☐ Site Care (specify) ☐ Administer Insulin ■ Medication Teaching Line Protocol (specify) ☐ Prepare Insulin Syringes ☐ Evaluate Med Effects/Compliance □ Blood Glucose Monitoring PRN or ___ ☐ Set up Meds Every ____ Weeks PRN Visits for IV Complications ☐ Administer medication(s) (name, dose, ☐ Teach Diabetic Care ☐ Anaphylaxis Protocol (specify orders) □ Other route, frequency)_ MATERNAL/CHILD ☐ Evaluate Fetal/Maternal Status ☐ Administer medication(s) (name, dose, Other ☐ Evaluate Growth and Development route, frequency)_ ■ Evaluate Parenting RESPIRATORY ☐ Teach S/S of Preterm Labor □ O₂ at liters per minute ☐ Teach Growth and Development ☐ Administer medication(s) (name, dose, ☐ Pulse Oximetry: Every Visit ☐ Teach Apnea Monitor Use ☐ Pulse Oximetry: PRN Dyspnea route, frequency)_ Other ☐ Teach Oxygen Use/Precautions ☐ Teach Trach Care **LABORATORY** □ Administer Trach Care □ Venipuncture for ☐ Administer IV medication (name, dose, □ Other Other

route, frequency and duration)_

☐ Teach IV Administration

INTEGUMENTARY

■ Wound Care (specify each site)

Patient Name PROFESSIONAL SERVICES (Cont'd.) Locator #21 Complete this section only when 485/POC is completed □ Adaptive Equipment **HOME HEALTH AIDE -**PT - FREQUENCY/DURATION FREQUENCY/DURATION ☐ Evaluation and Treatment ☐ Therapeutic Exercise ☐ Personal Care for ADL Assistance ☐ Muscle Re-Education ☐ Pulse Oximetry PRN Other (specific task for HHA) ____ ☐ Home Safety/Falls Prevention ☐ Establish Home Exercise Program ☐ Therapeutic Exercise ☐ Homemaker Training ☐ Modality (specify frequency, duration, □ Transfer Training ☐ Gait Training (amount)_ OTHER SERVICES (specify)_ ☐ Establish Home Exercise Program FREQUENCY/DURATION_ □ Other ☐ Modality (specify frequency, duration, ☐ Homemaking amount)__ Other ST - FREQUENCY/DURATION_ ■ Evaluation and Treatment MSW - FREQUENCY/DURATION □ Prosthetic Training ☐ Voice Disorder Treatment ☐ Muscle Re-Education ☐ Evaluate and Treat ☐ Speech Articulation Disorder Treatment □ Other ☐ Evaluate Family Situation □ Dysphagia Treatment Evaluate/Refer to Community Resources **OT - FREQUENCY/DURATION** ☐ Receptive Skills Evaluate Financial Status ☐ Expressive Skills ☐ Evaluation and Treatment Other_ ☐ Pulse Oximetry PRN ☐ Cognitive Skills ☐ Home Safety/Falls Prevention Other REHABILITATION POTENTIAL / GOALS Locator #22 Check goal(s), circle for specifics and insert information. DISCIPLINE GOALS AND DATE WILL BE ACHIEVED **Nursing:** Occupational Therapy: ☐ Demonstrates ability to follow home exercise program by ☐ Demonstrates compliance with medication (date) by _____ (date) ☑ Other \ by ___ ☐ Stabilization of cardiovascular pulmonary condition by _____ (date) Speech Therapy: ☐ Demonstrates competence in following medical regime Demonstrate swallowing skills in formal/informal dysphagia by _____(date) evaluation exercise program by _____ (date) ☐ Verbalizes pain controlled at acceptable level ☐ Completes speech therapy program by _____ (date) by (date) ☐ Demonstrates independence in _ Other (date) (date) Aide: ☐ Verbalizes/Demonstrates independence with care ☐ Assumes responsibility for personal care needs ____(date) by ____ (date) ☐ Wound healing without complications by _ (date) Other _ by _____ (date) ☐ Expect daily SN visits to end by _ (date) □ Other__ **Medical Social Services:** (date) ☐ Verbalize information about community resources and how to obtain Physical Therapy: assistance by _____ (date) ☐ Demonstrates ability to follow home exercise program __ by ____ (date) □ Other by (date) ☐ Other by _ (date) **DISCHARGE PLANS** ☐ Return to an independent level of care (self-care) ■ Medical condition stabilizes ☐ Able to remain in residence with assistance of primary ☐ When maximum functional potential reached caregiver/support from community agencies Other___ ☐ When patient knowledgeable about when to notify physician Other ☐ Able to understand medication regime and care related to diagnoses DISCUSSED WITH PATIENT: ☐ Yes ☐ No REHAB POTENTIAL: Poor Fair Good Excellent SIGNATURE/DATES X
Patient/Caregiver (if applicable)

Person Completing This Form (signature/title)

ID# Patient Name **CARE SUMMARY** Dear Doctor_ This Care Summary is for your information. Thank you for allowing us to care for your patient. **Disciplines Involved** Comments □ SN ☐ PT □ OT □ ST ☐ HHA □ MSW □ Other Other_ □ POT485 attached for signature. Please sign and return. □ Copy of Care Summary sent Date of last home visit____/___/ SUPERVISORY VISIT: Yes No SUPERVISORY VISIT: Scheduled Unscheduled STAFF: Present Onto present CARE PLAN UPDATED: No Yes CARE PLAN FOLLOWED: ☐ Yes ☐ No (explain)____ IS PATIENT/FAMILY SATISFIED WITH CARE: ☐ Yes ☐ No (explain)___ OBSERVATION OF TEACHING/TRAINING OF _____ NEXT SCHEDULED SUPERVISORY VISIT: SUMMARY CHECKLIST CARE PLAN: ☐ Reviewed/Revised with patient involvement ☐ Outcome achieved **MEDICATION STATUS:** Check if any of the following were identified: ☐ Potential adverse effects/drug reactions ☐ Ineffective drug therapy ☐ Significant side effects ☐ Significant drug interactions ☐ Duplicate drug therapy ☐ Non-compliance with drug therapy ☐ No change ☐ Order obtained BILLABLE SUPPLIES RECORDED? • Yes • Yes DME AND SUPPLIES: (Locator #14) ____ CARE COORDINATION: Depreción Defenda Description Descr REFERRAL TO:___ APPROXIMATE NEXT VISIT DATE: PLAN FOR NEXT VISIT: Recertification order obtained: No Versal order obtained: No Yes, specify date (Locator #23) HOMEBOUND REASON (if applicable) ☐ Confusion, unable to go out of home alone ☐ Dependent upon adaptive device(s) ☐ Needs assistance for all activities Medical restrictions ☐ Residual weakness ☐ Unable to safely leave home unassisted ☐ Requires assistance to ambulate ☐ Severe SOB, SOB upon exertion Other (specify) SUMMARY Complete this Section for Recertification (Unless 60 day Summary is written elsewhere) REASON FOR ADMISSION (describe condition) SUMMARY OF CARE (including progress toward goals to date) ___ **DISCHARGE PLANNING** (specify future follow-up, referrals, etc.) Signature/Title of Person Completing This Form_____ _ Date____/

ORIGINAL — Clinical Record
(Provide copy to Physician per agency policy)

Phone #

Agency Name