Perspective Home Health, Inc.

Evaluation Consultation Note

Patient's Name: _____ DOB: _____

Ethnicity: _____ Marital Status: ☐Single ☐Married ☐Divorce ☐Widow

Where the patient was admitted from: ☐Hospital ☐Rehab ☐SNF ☐MD

Admission date from hospital: _____

D/C date from hospital: _____

ER: ☐Yes ☐No _____

Name of Hospital: _____

PCP _____ Date of last visit with PCP (important): _____

Surgeon: _____ Specialist being seen: ☐Neuro ☐Uro ☐Pulmo ☐Nephro ☐Gastro ☐Pain Mgmt

Type of Surgery: _____ Other: _____

Date: _____ MD names: _____

Pharmacy: _____ Specialty Pharmacy: _____

Phone number: _____ Drug: _____

Emergency Contact: Name: _____ Phone Number: _____

Disaster Code Priority: ☐ IV ☐III ☐II ☐I

Influenza (Flu): ☐Yes ☐No Date: _____ Tetanus: ☐Yes ☐No Date: _____

Pneumonia: ☐Yes ☐No Date: _____ Shingles: ☐Yes ☐No Date: _____

Primary Dx for HHC:	Medical Hx:

Homebound Status: ☐Medical Restrictions ☐Residual Weakness ☐Chair/ Bedbound ☐Confusion ☐ Severe SOB, SOB upon exertion ☐Requires assistance to ambulate/ dependent upon adaptive device

Advanced Directives: ☐DNR/ DNI ☐Living Will ☐MED POA ☐Other: _____ Name of POA: _____

Living Arrangement: ☐Alone ☐With Others ☐Congregate Situation

How often does patient receive assistance: _____

Allergies: _____ Diet: _____

Vitals:	BP	Pulse	Resp	Temp	Height:	Weight:

Baseline Mental Status: AO X _____ Cognitive Status: _____ Hx of noncompliance: ☐Yes ☐No

Pain: _____/ 10	Frequency: _____	Location: _____	Relieved by: _____

Eyes: ☐WNL ☐Other: _____

Ears: ☐WNL ☐Other: _____

Nose: ☐WNL ☐Other: _____

Throat: ☐WNL ☐Other: _____

Dentures: ☐Upper ☐Lower ☐ Full ☐Partial

Fluid Intake: _____ _____

Appetite: ☐Good ☐Fair ☐Poor

☐Smoker: Packs/ Day _____

☐Alcohol: Bottles/ Day _____

Other: _____

Diet: ☐Regular ☐Diabetic ☐Renal ☐Low Added Salt ☐No Salt ☐Low fat ☐Low cholesterol ☐Controlled Carbohydrates ☐No concentrated sweets

Other: _____

Diabetes Mellitus: Last reading level: _____

Date: _____ Time: _____

☐Fasting

How often BS check _____

Other: _____

Coumadin (Warfarin): ☐Yes ☐No

Managed by : ☐PCP ☐Cardiologist (MD name) ☐Coumadin Clinic

Name/ Place: _____

Other: _____

Breath Sounds: _____

Patient on O2? ___ LPM ☐Continuous ☐PRN, ☐Nighttime only via ☐Nasal Cannula ☐Mask

Other: _____

☐Dyspnea ☐Cough ☐Trach (Size/ Type): _____

Heart sounds: _____ ☐Pacemaker

Edema: Location: _____

☐Non-pitting ☐Pitting: ☐+1 ☐+2 ☐+3 ☐+4

☐PICC (Location): _____

☐IV: (Gauge/ Location): _____

Perspective Home Health, Inc.

Evaluation Consultation Note

Wound Location/ Type: _____
Drainage amount/ Type: _____
Pressure Ulcer Stage:☐ I ☐II ☐III ☐IV ☐Unstageable or N/A
SN to manage wound: ☐Yes ☐No
Picture Taken: ☐Yes ☐No
Other: _____

Wound Location/ Type: _____
Drainage amount/ Type: _____
Pressure Ulcer Stage:☐ I ☐II ☐III ☐IV ☐Unstageable or N/A
SN to manage wound: ☐Yes ☐No
Picture Taken: ☐Yes ☐No
Other: _____

Patient seeing ☐Wound Tech ☐Wound MD
If WC MD, Name: _____

Scheduled Days for wound HH visits: (ex. Mon/ Wed):_____

Patient is on ☐ IV Antibiotics ☐Oral Antibiotics
Duration: _____

SN to manage : ☐Yes ☐No
Specialty Pharmacy Managing: _____

Drains: ☐PEG Tube ☐PEJ Tube ☐Nasogastric ☐ JP Drain ☐Aspira Drain ☐Pleur X Drain ☐Biliary Drain
☐Other:_____ SN to manage: ☐Yes ☐No

Urine appearance:_____
Urinary continence status:_____
UTI: ☐In past 14 days ☐chronic ☐acute
☐Hemodialysis: Days/ Time: _____
Location: _____

☐Urinary Catheter (type):_____
French:_____ Inflated with:_____
Last Changed: _____ SN to manage: ☐Yes ☐No
Frequency of BM: _____
BM continence status: _____
Other:_____

Muscle Weakness: _____
Orthopedic aftercare:_____
☐DME:_____
Recommended Services: ☐PT ☐OT ☐CHHA

Patient ambulates with : _____
☐Recent falls in past 3 months Last Fall: _____
Other: _____

Patient requires _____ help with:

Bed mobility	☐Ind ☐Supervision ☐Min ☐Mod ☐Max	Transfers	☐Ind ☐Supervision ☐Min ☐Mod ☐Max
Getting dressed	☐Ind ☐Supervision ☐Min ☐Mod ☐Max	Going up/ down stairs	☐Ind ☐Supervision ☐Min ☐Mod ☐Max
Bathing	☐Ind ☐Supervision ☐Min ☐Mod ☐Max	Meal prep	☐Ind ☐Supervision ☐Min ☐Mod ☐Max
Toileting	☐Ind ☐Supervision ☐Min ☐Mod ☐Max	Medications	☐Ind ☐Supervision ☐Min ☐Mod ☐Max

Oral Medications administered by :_____
Injectable Medications administered by: _____

If SN Eval only, explain why:

☐Patient/ PCG able to demonstrate proper management of Disease Process
☐Patient/ PCG able to demonstrate proper management of Medications
☐Patient/ PCG able to demonstrate knowledge of EMS protocol
☐Patient/ PCG able to demonstrate ability to continue care (wound, PEG, ostomy, etc.)
☐Patient refused further SN care
☐Patient/ PCG refuse further skilled home health care
☐Patient mainly needs therapy services
☐Patient non-compliant
Other: _____

HHA services needed and frequency (e.g., 1wk1)

SN: Frequency: _____
PT: Frequency: _____
OT: Frequency: _____
ST: Frequency: _____
RD: Frequency: _____
MSW: _____
CHHA: Frequency: _____
Other: _____

Rationale for above reason/ frequency

☐Pt/ PCG Knowledge deficit (Disease Process/ Medications/ Safety/ DME, etc.)
☐Knowledge Deficit:
_____
☐Wound management
☐Urinary Catheter Management
☐Unable to provide safe self-care
☐No PCG Assistance/ reliable caregiver
☐Risk for falls
☐Presence of rehab/ learning potential
☐Other Skilled needs:
_____
☐Other:
_____

Clinician Name:

Date: