Jewish Tradition Home Care

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INITIAL NURSING ASSESSMENT: PLAN OF TREATMENT

Patient Name: _____ **MR#**: _____ **DOB**: _____
Patient Address: _____
Patient Phone: _____ **Sex**: **Male**_____ **Female**_____
SOC Date: _____**Certification Period**: **From:**_____**To**:_____
Visit Schedule: **Routine**:_____**60 Day**:____**180 Day**: ____**Special Reason**: _____
Diagnosis:#1: _____ **#2**: _____
Allergies: _____

MEDICAL HISTORY

_____
_____
_____
_____
_____
_____
_____

PHYSICAL ASSESSMENT

Vital Signs: Temp: _____ **Pulse**:_____ **Respirations**: _____ **BP**: _____ **Weight**: _____
Neurological: Gait: _____ **Balance**: _____ **Tremors**: _____
Seizures: _____
Mental Status: **Oriented**: _____**Forgetful**: _____ **Disoriented**: ____**Confused**: _____
Agitated: _____**Lethargic**: _____ **Comatose**: _____
E.N.T.: _____
Respiratory: _____
Cardiovascular: _____
_____
G.I.: _____
Diet: _____**Appetite:** _____
G.U.: _____
Musculoskeletal: _____ **Skin**: _____

FUNCTIONAL LIMITATIONS

Ambulation: _____ **Amputation**: _____ **Contracture**: _____
Paralysis: _____ **Endurance**: _____ **Feeding**: _____
Sight: _____ **Speech**: _____ **Hearing**: _____
Incontinence: Bladder: _____ **Bowel**: _____

Patient Name: _____

ACTIVITY A=with assistance I=independent

Bed rest: _____ Transfer: _____ Up as tolerated: _____ Walk: _____
Bath/Shower: _____ Dressing: _____ Feeding: _____ Toileting: _____

SAFETY MEASURES AND EQUIPMENT NEEDS

_____
_____
_____

MEDICATIONS **ASSISTANCE REQUIREDWITH SELF ADMINISTRATION OF MEDICATIONS: YES: _____ NO: _____**

Name	Dose	Frequency	Route	New/Changed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ORDERS FOR DISCIPLINE AND TREATMENT

_____
_____
_____
_____
_____

Last M.D. Visit: Date: _____ Next M.D. Visit: Date: _____

PROGNOSIS

Poor: _____ Fair: _____ Guarded: _____ Good: _____ Excellent: _____

GOALS

_____
_____
_____
_____

Patient Name: _____

COMMENTS

_____
_____
_____
_____
_____
_____
_____

_____ _____

Physician Signature/Date **Registered Nurse Signature/Date**

Name: (printed) _____ **Name: (printed) _____**
Address: _____
_____
Phone: _____
Fax: _____