



Day Program Initial Nursing Evaluation and Physical Health Screening Tool

Person Served: _____ Location: _____

Diagnoses: _____

Allergies: _____

Diet: _____

Medications: _____

Hospitalizations: _____

Temperature: _____ Pulse: _____ Blood Pressure: _____ Respirations: _____

Breath Sounds: _____

Alert & Oriented: Person Place Time Environment

Communication: Verbal Non-Verbal Gestures Sign Language

Eyes: Conjunctiva Clear Other: _____

Sclera White Other: _____

Pupils: Equal and reactive to light Other: _____

Abdomen: Soft & Non-Tender Firm & Non-Tender Hard & Non-Tender

Soft & Tender Firm & Tender Hard and Tender

Bowel Sounds: _____

Skin Turgor: Good Fair Poor

Mouth: All Teeth Dentures Edentulous Missing Teeth

Capillary Refill: < 3 Seconds > 3 Seconds

Edema: None Other: _____

Skin: Intact Other: _____

Weight: _____ Height: _____

Day Program Initial Nursing Evaluation and Physical Health Screening Tool

Person Served: _____

Location: _____

CATEGORY:

Eating	<input type="checkbox"/> Independent	<input type="checkbox"/> Assistance	<input type="checkbox"/> Dependent	<input type="checkbox"/> Tube Feeding
Appetite	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Ambulation	<input type="checkbox"/> Independent	<input type="checkbox"/> Assistance	<input type="checkbox"/> Wheelchair	
Transferring	<input type="checkbox"/> Independent	<input type="checkbox"/> Minimal Assist	<input type="checkbox"/> Total Assist	
Toileting	<input type="checkbox"/> Independent	<input type="checkbox"/> Supervision	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Catheter
Aggression	<input type="checkbox"/> None	<input type="checkbox"/> <5/month	<input type="checkbox"/> >5/month	<input type="checkbox"/> BMP
Self-Abuse	<input type="checkbox"/> None	<input type="checkbox"/> <5/month	<input type="checkbox"/> >5/month	<input type="checkbox"/> BMP
Psychotropic Medications	<input type="checkbox"/> None	<input type="checkbox"/> Yes		
Seizures	<input type="checkbox"/> None	<input type="checkbox"/> >1/year	<input type="checkbox"/> <2/month	<input type="checkbox"/> >2/month
Anticonvulsant Medications	<input type="checkbox"/> None	<input type="checkbox"/> Yes		
Skin Breakdown	<input type="checkbox"/> None	<input type="checkbox"/> At Risk	<input type="checkbox"/> Breakdown	
Bowel Function	<input type="checkbox"/> Normal	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Medications
Diet	<input type="checkbox"/> Regular	<input type="checkbox"/> Special		
Sleep	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Adaptive Devices	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Glasses	<input type="checkbox"/> Dentures	

COMMENTS:

Day Program Initial Nursing Evaluation and Physical Health Screening Tool

Person Served: _____

Location: _____

Medication Review:

1. _____
2. _____
3. _____
4. _____
5. _____

*** Care Plan to be developed***

At the time of this evaluation, the above-mentioned person served health care needs appear to be chronic, stable, uncomplicated, routine, predictable and the environment is conducive to delegation of nursing tasks.

Potential Need for C.N.A. Refer to HRST

Does Not Require C.N.A.

Registered Nurse Name: _____

Date: _____

Signature: _____