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**:______________		

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CATEGORY:

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