INTEGRITY HOME HEALTH CARE SERVICES ADMISSION CHECKLIST

PATIENT NAME: _____ **TYPE OF VISIT:** _____ **DATE & TIME OF VISIT:** _____

DOB:

SS#:

Ethnicity:

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican, ☐ Yes, Cuban
☐ Yes, another Hispanic, Latino, or Spanish origin
☐ Patient unable to respond
☐ Patient declines to respond

Race:

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian, ☐ Chinese,
☐ Filipino, ☐ Japanese,
☐ Korean, ☐ Vietnamese
☐ Other Asian,
☐ Native Hawaiian,
☐ Guamanian or Chamorro,
☐ Samoan
☐ Other Pacific Islander
☐ Patient unable to respond
☐ Patient declines to respond
☐ None of the above

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Y / N / Unable To Respond / Declines To Respond

Any other agency providing services to you? Y / N

If yes, name/phone/svcs provided:

Religion:

Allergies & Reaction:

Ht: ***Wt:***

Wt gain / loss, how much?

In last _____ days / wks / mos

Vital Signs

Parameters:
TEMP: >101.6 OR <95
PULSE: >100 OR <60
RESPIRATIONS: >30 OR <14
SYSTOLIC BP: >160 OR <90
DIASTOLIC BP: >90 OR <60
O2 SAT: <90%
FASTING/RANDOM BLD SUGAR: >300 OR <60
WEIGHT (CHF PATIENTS): Gain OF >2 lbs/2 days or >5 lbs /1 wk

Pulse –
Reg / Irreg / Strong / Weak

Temp –
Oral/ Rectal/ Axilla/ Tymp/ Tempo

Resp – O2 Sat -

Lung Sounds:

O2? _____ L via NC, Mask, Trach

BP –
L / R / Sitting / Standing / Lying

Immunizations

Pneumo Vax: Y / N, When?

Flu Vaccine: Y / N, When?

Tetanus Shot? Y / N, When?

TB Test? Y / N, When?

TB Exposure? Y / N, When?

Hep B Vax? Y / N, When?

Shingles Vax: Y / N, When?

Health Screening (Indicate dates)

Last Cholesterol Level done:

Last Mammogram done:

Do you perform monthly self-breast exams? Y / N

Last Pap Smear done:

Last PSA done:

Last Prostate Exam done:

Last Colonoscopy done:

Living Arrangement/Support

Lives alone?

Who helps you at home, and how often?

Hazards identified at home?

EENT

Date of Last Eye Exam?

Glasses?

HOH, Hearing Aid?

Dentures? Uppers / Lowers

Do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Never / Rarely / Sometimes / Often / Always / Declines / Unable to respond

Advance Care Planning

Complete Coordination of Care Form

Conduct Brief Interview for Mental Status (BIMS)

(Skip if patient is unresponsive)

Intent: to determine the patient's attention, orientation, and ability to register and recall information.

Ask patient ***"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: SOCK, BLUE, and BED.*** **– You may repeat the words up to two more times or** ***SEE LAST PAGE AND SHOW CUE TO PATIENT IF NEEDED***

Can you please tell me the three words?"

How many of the 3 words was patient able to repeat? 1 / 2 / 3 / Not Assessed

Temporal Orientation Questions:

"Please tell me what YEAR it is right now"

☐ Missed by > 5 years **or no answer**
☐ Missed by 2-5 years
☐ Missed by 1 year / ☐ Correct

"What MONTH are we in right now?"

☐ Missed by > month **or no answer**
☐ Missed by 6 days to 1 month
☐ Accurate within 5 days
☐ Not assessed / No info

"What day of the WEEK is today?"

☐ Incorrect **or no answer**
☐ Correct

Recall Question:

"Let's go back to an earlier question. What were those three words that I asked you to repeat?" **If unable to remember a word, give cues for each word - something to wear, a color, a piece of furniture.**

Able to recall "sock"? Y / N

Able to recall "blue"? Y / N

Able to recall "bed"? Y / N

Patient Mood Interview (PHQ-2 to 9)

Dementia: Y / N

Depression Screening:

Ask patient: Over the last 2 weeks, how often have you been bothered by any of the following problems:

1. **Little interest or pleasure in doing things? (Circle one below)**

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

2. **Feeling down, depressed or hopeless? (Circle one below)**

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

ONLY PROCEED TO INTERVIEW BELOW If either 1 or 2 above (Symptom Frequency) is 7-11 Days (half or more of the days) or 12-14 days (nearly every day) - CONTINUE asking the questions below.

Trouble falling or staying asleep, or sleeping too much

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

Feeling tired or having little energy

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

Poor appetite or overeating

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

Feeling bad about yourself - or that you are a failure or have let yourself or your family down

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

Trouble concentrating on things, such as reading the newspaper or watching television

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

Thoughts that you would be better off dead, or of hurting yourself in some way

Not at all / 2-6 days-Several days / 7-11 days-half or more of the days / 12-14 days-Nearly everyday / NA (unable to respond)

ADL/Mobility – Think Safety!

TUG Score:

Gait Instability: Y / N

History of Falls: Y / N

If recent fall, when?

DME/Supplies

List all DME already have and indicate if used prior to current illness/injury:

List DME's needed and why:

GI/GU

Last BM: BM Freq:

Colostomy?

Voiding ok?

Foley/Supra, Last changed?

Foley size:

___ Fr, ____ ml balloon

Incontinence: Bowel / Urine

Recent UTI, when:

Dialysis? If yes, where?

Schedule? MWF or TThS

Dialysis Time start:

Pain (take note of pain med)

Location:

Date of Onset:

Duration: Constant / Intermittent

Current level:

Description:

What makes it worse:

What makes it better:

Pain Effect on Sleep

Does not apply / Rarely or not at all / Occasionally / Frequently / Almost constantly /
Unable to answer

Pain Interference with Therapy Activities

Does not apply / Rarely or not at all / Occasionally / Frequently / Almost constantly /
Unable to answer

Pain Interference with Day-to-Day Activities

Does not apply / Rarely or not at all / Occasionally / Frequently / Almost constantly /
Unable to answer

Endocrine

Diabetic? Y / N

BS level and when taken:

How often and by Whom:

If on insulin, when started?

Cardiovascular

Dx'd with PVD or PAD? Y / N

Edema:

Nonpitting / Pitting: 1+, 2+, 3+, 4+

If CHF, check Wt now:

Then instruct daily weights check

Pacemaker, date implanted:

AICD, date implanted:

Nutrition

Eating ok?

Swallowing issues?

Tube Feed?

Type of tube:

Feed/Dose/Freq:

Check all of the following treatments, procedures, and programs that apply

Cancer Treatments

☐ Chemotherapy
☐ IV
☐ Oral
☐ Other
☐ Radiation

Respiratory Therapies

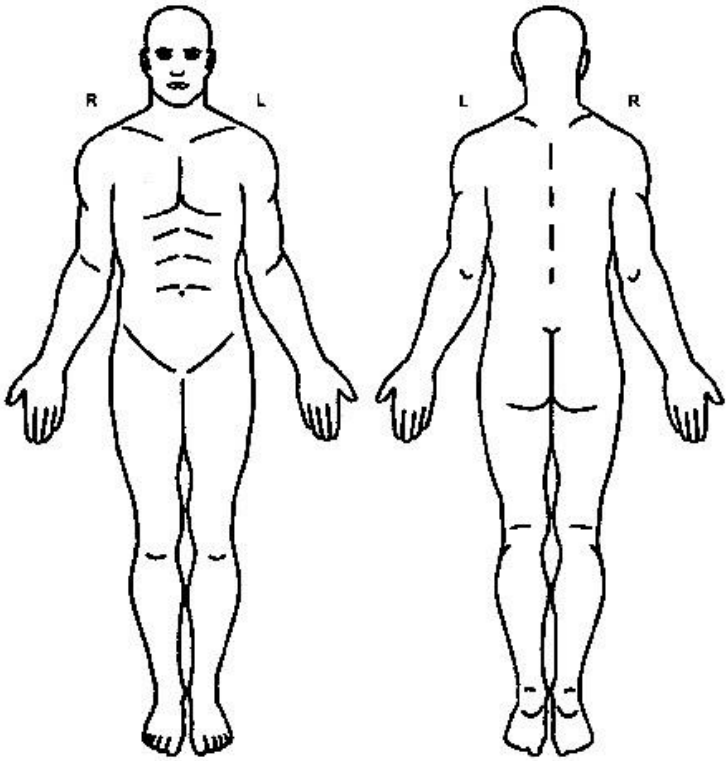
☐ Oxygen Therapy
☐ Continuous
☐ Intermittent
☐ High-concentration
☐ Suctioning
☐ Scheduled
☐ As Needed
☐ Tracheostomy care
☐ Invasive Mechanical Ventilator (ventilator or respirator)
☐ Non-invasive Mechanical Ventilator
☐ BiPAP
☐ CPAP

Other

☐ IV Medications
☐ Vasoactive medications
☐ Antibiotics
☐ Anticoagulation
☐ Other
☐ Transfusions
☐ Dialysis
☐ Hemodialysis
☐ Peritoneal dialysis
☐ IV Access
☐ Peripheral
☐ Mid-line
☐ Central (e.g., PICC, tunneled, port)
☐ **None of the Above**

IV Infusion	***Any additional information not listed in our h&p:***	***Additional Notes:***
When placed?: Type of Line: # of Lumens: Location: ECL (Ext Cath Length): Baseline Arm Circum if PICC: Last dsg change: ***CIRCLE DISCIPLINE YOU ARE RECOMMENDING AND REASON WHY. <u>CALL AND GET VERBAL AND INFORM OFFICE IF YOU RECVD A VERBAL ORDER.</u>*** SN – PT – OT – ST – MSW – DIETICIAN – HHA – ***Recent hospitalizations in the last 6 months:*** ***List all surgical history and dates:***	***REMINDERS/CHECKLIST:*** ○ ***YOUR FREQUENCY –*** ○ ***PLEASE TEXT TO OFFICE THAT SOC IS DONE WITH TIME IN/OUT AND FREQUENCY*** *(WE HAVE TO SUBMIT NOTIFICATION TO MEDICARE THAT PATIENT HAS BEEN SOC'D BY HOME HEALTH WITHIN 5 ACTUAL DAYS OF SOC)* ○ ***OFFER TO RECOMMEND OUR MSW TO HELP WITH ADVANCE DIRECTIVES IF NEEDED.*** ○ ***COMPLETE SOC PHYSICIAN ORDER ASAP IN KINNSER UNDER ORDER TAB.*** ○ ***COMPLETE SOC OASIS WITHIN 48 HOURS*** ○ ***UPDATE PHARMACY NAME AND PHONE WHEN ENTERING MEDS IN KINNSER*** ○ ***TEXT OFFICE FOR WOUND CARE SUPPLIES IF NEEDED*** ○ ***PLS COMPLETE BRADEN SCALE ASSESSMENT FORM AND SUBMIT***	

Integumentary



	#1	#2	#3	#4	#5
Location					
Onset Date					
Size					
Drainage					
Odor					
Etiology					
Stage					
Undermining					
Inflammation					
Comments					

****** PLS COMPLETE BRADEN SCALE ASSESSMENT FORM AND SUBMIT ******

Is patient currently using any pressure-relieving device? Y / N, if yes, what type?

List wound care supply needs, if applicable:

Functional Abilities and Goals

Prior Functioning

Choices: 3-Independent 2-Needed some help 1-Dependent 8-Unknown 9-Not applicable - Not assessed/No info

Self-care (bathing, dressing, toileting, eating):

Indoor Mobility (ambulation):

Stairs:

Functional Cognition:

Choices for below questions:

06-Independent	***07-Patient refused***
05-Setup or cleanup	***09-Not applicable***
04-Supervision or touch A	***10-Not attempted due to environmental limitation***
03-Partial/mod A	***88-Not attempted due to medical conditions or safety concerns***
02-Max A	***- Not assessed/No info***
01-Dependent	

Self-Care

Ask the patient/caregiver - How are you able to manage the following self-care activities

Eating?

Oral Hygiene?

Toileting Hygiene?

Shower/bathe self?

Upper body dressing?

Lower body dressing?

Putting on/taking off footwear?

Mobility

Ask the patient/caregiver - How are you able to manage the following self-care activities

Roll left and right in bed?

Sit to lying, lying to sitting on side of bed?

Sit to stand?

Chair/bed to chair transfer?

Toilet transfer?

Car Transfer?

Walking 10 feet?

(Only answer below questions with #10 or #88 if applicable)

Walking 50 feet with 2 turns?

Walking 150 feet?

Walking 10 feet on eneven surfaces?

Walking up or down 1 step?

Walking up or down 4 steps?

Walking up or down 12 steps?

Picking up object?

Do you use a wheelchair? (circle if any) Standard / Motorized

Able to wheel 50 feet with 2 turns?

Able to wheel 150 feet?

REMEMBER THESE 3 WORDS BELOW:

SOCK

BLUE

BED