SAMPLE
NURSING ASSESSMENT

(For Nurses of Individuals with Developmental Disabilities)

DATE OF ASSESSMENT:	COMPLETED BY:

NAME:	D.O.B.:	AGE:
ADDRESS:		PHONE:
AGENCY NAME:		PHONE:
ADDRESS:		

VITALS:

B/P:	PULSE:	RESPIRATIONS:	TEMPERATURE:

ALLERGIES:

ADVERSE DRUG REACTIONS:

CURRENT MEDICAL DIAGNOSIS	RELATED MEDICATIONS/TREATMENTS

SELF ADMINISTRATION OF MEDS:	Yes:	No:	If yes, do they have a training program ? Yes____ No____ Or, are supports in place? Yes_____ No_____

X-RAY/LAB TESTS	FREQUENCY	LAST DONE	RESULTS	DATE DUE

ELIMINATION:

	Continent	Monitored	Constipation
B.M.:	Yes______ No_____	BMs Recorded: Yes_____ No_____ Toilets Independently: Yes______ No____ Frequency (if known):___________________________	Yes______ No_______
Urine:	Yes______ No_____	Output recorded: Yes_____ No____ Toilets Independently: Yes_____ No_____ Frequency (if known) ____________________________	

IMMUNIZATIONS/SCREENINGS:

Tetanus/Diphtheria	Last Immunization:	Booster due:
Hep B Status	Antibody Test:	Immunizations:
TB Screening	Date:	Results
Other Immunizations Done Last Year:	Date:	Type:
Immunizations Due This Next Year:	Date:	Type:

COMMUNICATION: (How the client communicates pain/illness)

PATTERNS OF COPING AND INTERACTING:

CULTURAL, SPIRITUAL NEEDS (if known):

FAMILY HEALTH HISTORY (Significant illness/diseases) if known:

WEIGHT

Height:	Current Weight:	Ideal Body Weight Range:
Weight 1 year ago:		
History of weight loss or gain?		
Underweight: lbs.	Overweight: lbs.	
Comments:		

NUTRITIONAL STATUS:	Intake Documented? Yes_______ No_______		
Current Diet Order (including texture, if specified):			
Average daily fluid intake:		Recommended Fluid Intake:	
Risk of Aspiration or choking:		Yes:	No:
Fed by: Staff_______________ Self________________		Has a Dining Skills Card? Yes________ No_________ Date Dining Skills Card last updated:	
Typical Appetite:			
Specify problems chewing, swallowing, refusal to eat, over eating, etc:			
Dietician Services:	Yes:	No:	Reports Reviewed:
Occupational Therapy or Speech Language Pathologist Services for swallowing (specify which):	Yes: What Service:____________	No:	Reports Reviewed:

ADAPTED EQUIPMENT FOR EATING OR DRINKING	

PHYSICAL STATUS/MOVEMENT

Mobility status: (Be specific: i.e., independent, walks with walker, walks with 2-person assist.)

Assistance needed to complete the following ADLs (specify type of assist):

Bathing:____

Oral Hygiene____

Dressing____

Positioning Record Kept: Yes_____ No_____	Frequency of review by RN__________________________ Last reviewed by RN: ______________________________ (date)

Transfer Abilities (Be specific: independent vs. 2 person, stand pivot, etc)

Frequency of repositioning:

Has Range of Motion Program? Yes_____ No______

Physical Therapist	Yes:	No:	Reports last reviewed by RN___________________
Occupational Therapist	Yes:	No:	Reports last reviewed by RN_____________________

MEDICAL EQUIPMENT FOR PHYSICAL MANAGEMENT:	**LEVEL OF ASSISTANCE REQUIRED WITH EQUIPMENT**

SYSTEMS REVIEW

MEDICAL PROBLEM LIST	BRIEF REVIEW OF PRIOR YEAR	CURRENT PHYSICAL STATUS
1. Allergy: (medication, food, fluid, environmental, etc)		
2. Skin, hair, nails: (dry skin, acne, etc.)		
3. Neurology: (seizures, spasticity, paralysis, hypothermia, etc.)		
4. Eyes: (vision, infection, corrective lenses, etc.)		
5. Ears: (hearing, infection, cerumen impaction, hearing aids, etc.)		
6. Dental: (periodontal disease, prosthetics, cavities, sedation needed for dental work, etc.)		
7. Endocrine: (thyroid, diabetes, etc.)		

SYSTEMS REVIEW

MEDICAL PROBLEM LIST	BRIEF REVIEW OF PRIOR YEAR	CURRENT PHYSICAL STATUS
8. Gastro-intestinal: (swallow, reflux, nutrition, intestinal, bowel, etc.)		
9. Muscular/skeletal: (spine-trunk, extremities, mobility, etc.)		
10. Respiratory: (asthma, bronchitis, pneumonia, etc.)		
11. Cardio-Vascular: (cardiac, B/P, vessels, anemia, etc.)		
12. Hepatic/Lymphatic: (Hepatitis, elevated liver enzymes, etc)		
13. Kidney/Bladder: (UTI, etc.)		
14. Reproductive Health: (menses, paps, mammogram, breast exams, Prostrate Specific Antigen etc.)		

SYSTEMS REVIEW

MEDICAL PROBLEM LIST	BRIEF REVIEW OF PRIOR YEAR	CURRENT PHYSICAL STATUS
15. Behavior/Psychiatric:* (Depression, Bi-Polar, sleep disorder,SIB, etc.)	(List all psychotropic meds by name)	
16. Health Maintenance: (flu shots, immunizations, lab, tests, etc)		
17. Other: (sleep/rest, weight, etc.)		
18. Other:		

*** If individual takes psychiatric/behavior medications they must be specified in the ISP.**

____ ____________________

(Signature of RN Conducting Assessment) (Date)