Deinstitutional Services Assessment

Resident's Name: _____ Date: _____
Address: _____ Date of Birth: _____
City, State, Zip: _____ Age: _____ Phone: _____
Marital Status: _____ Race: _____ Education Level: _____
Primary Language: _____ Translator Needed: ☐ Y ☐ N
Translation to be provided by: _____

Interview participants other than resident: _____

Insurance Information:
SSN: _____ Medicare/RRB #: _____ Medi-Cal #: _____
Other Insurance: _____

☐ Legal Guardian ☐ Conservator ☐ Durable Power of Attorney
Translator Needed: ☐ Y ☐ N
Name: _____ Address: _____ Phone: _____

Emergency: Relationship to Resident: _____
Name: _____ Address: _____ Phone: _____

Physician:
Name: _____ Address: _____ Phone: _____

Referral Source: _____

Section 1: Diagnoses

Diagnoses: Check diagnosis here if (1) It is provided by a health care provider, or (2) you see it written in a medical record (including hospital discharge forms, nursing facility admission forms, etc.), or (3) if resident or informant can state it. Note source in Comments section. Statements should be confirmed by resident's medical records.

A. Endocrine/Metabolic:	Comments
☐Dehydration/Fluid & Electrolyte Imbalances ☐Diabetes Mellitus ☐Hypothyroidism/Hyperthyroidism ☐Liver Disease (Hepatic Failure, Cirrhosis) ☐Nutritional Imbalances (e.g., Malnutrition, Vitamin Deficiencies, High Cholesterol, Hyperlipidemia) ☐Other Disorders Of Digestive System (Mouth, Esophagus, Stomach, Intestines, Gall Bladder, Pancreas) ☐Other Disorders of Hormonal or Metabolic System	
B. Heart/Circulation:	**Comments**
☐Anemia/Coagulation Defects/Other Blood Diseases ☐Angina/Coronary Artery Disease/Myocardial Infarction (MI) ☐Congestive Heart Failure (CHF) ☐Disorders of Blood Vessels or Lymphatic System ☐Disorders of Heart Rate or Rhythm ☐Hypertension (HTN) (High Blood Pressure) ☐Hypotension (Low Blood Pressure) ☐Other Heart Conditions (Including Valve Disorders)	

C. Musculoskeletal/Neuromuscular:	Comments
☐Amputation ☐Arthritis (e.g., Osteoarthritis, Rheumatoid Arthritis) ☐Contractures/Connective Tissue Disorders ☐Hip Fracture/Replacement ☐Multiple Sclerosis/ALS ☐Muscular Dystrophy ☐Osteoporosis/Other Bone Disease ☐Paralysis Other Than Spinal Cord Injury ☐Parkinson's Disease ☐Spinal Cord Injury ☐Other Chronic Pain/Fatigue (e.g., Fibromyalgia, Migraines, Headaches) ☐Other: Fracture/Joint Disorders/Scoliosis/Hypnosis ☐Other Musculoskeletal, Neuromuscular, or Peripheral Nerve Disorders	
D. Brain/Central Nervous System:	**Comments**
☐Alzheimer's Disease ☐Cerebral Vascular Accident (CVA, stroke) ☐Seizure Disorder ☐Traumatic Brain Injury ☐Other Brain Disorders ☐Other Dementia	
E. Respiratory:	**Comments**
☐Tracheotomy ☐Asthma ☐Chronic Bronchitis ☐Chronic Obstructive Pulmonary Disease (COPD) ☐Emphysema ☐Pneumonia/Acute Bronchitis/Influenza ☐Ventilator Dependent ☐Other Respiratory Condition	
F. Disorders of Genitourinary/Reproductive Systems:	**Comments**
☐Incontinence ☐Renal Failure, Other Kidney Disease ☐Testicular/Prostate Problems ☐Urinary Tract Infection (UTI), Current or Recently Recurrent ☐Vaginal Problems ☐Other Disorders of GI System (Bladder, Urethra)	
G. Documented Mental Illness:	**Comments**
☐Anxiety Disorder (e.g., Phobias, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder) ☐Bipolar/Manic-Depressive ☐Depression ☐Schizophrenia ☐Other Mental Illness Diagnosis (e.g., Personality Disorder)	

H. Sensory:	Comments
☐Blind ☐Deaf ☐Hard Of Hearing ☐Visual Impairment (e.g., Cataracts, Retinopathy, Glaucoma, Macular Degeneration) ☐Other Sensory Disorders	
I. Infections/Immune System:	**Comments**
☐AIDS (Diagnosed) ☐Allergies ☐Auto-Immune Disease (Other Than Rheumatism) ☐Cancer in Past 5 Years ☐Diseases of The Skin ☐HIV Positive ☐Other Infectious Disease	
J. Other:	**Comments**
☐Alcohol or Drug Abuse ☐Behavioral Diagnoses (Not Found in Part G Above) ☐Terminal Illness (Prognosis ≤ 12 Months) ☐Wound, Burn, Bedsore, Pressure Ulcer ☐Other: Specify	

Section 2: Health-Related Services

Check only one box per row: Current Frequency Of Help/Services Needed From Other Persons

Health-Related Services Needed	**Person is independent**	**1 to 3 times/ month**	**Weekly**	**2 to 6 times/ week**	**1 to 2 times/ day**	**3 to 4 times/ day**	**Over 4 times/ day**	**Comments:** Any changes anticipated by date of discharge. Specify who will assume current help activities and source of payment, if any.
Interventions related to Behaviors								
CONDITION – REQUIRES NURSING ASSESSMENT or skilled medical monitoring by persons trained and overseen by nurse. Condition may be unstable or deteriorating (e.g., infections, gangrene, dehydration, malnutrition, terminal condition, exacerbation, AIDS) and/or result from multiple health risks in person unable to manage them or to communicate problems.								
IV CHEMOTHERAPY								
EXERCISES/RANGE OF MOTION								
IV FLUIDS								
IV MEDICATIONS (Drips or boluses, not chemotherapy)								
MEDICATION ADMINISTRATION (not IV) OR ASSISTANCE with pre-selected or set-up meds								
MEDICATION MANAGEMENT – Set-up and/or monitoring (for effects, side effects, adjustments) AND/OR blood levels								

OSTOMY-RELATED SKILLED SERVICES								
OXYGEN								
PAIN MANAGEMENT								
POSITIONING IN BED OR CHAIR every 2-3 hours								
RESPIRATORY TREATMENTS: Nebulizers, IPPB Treatments, BI-PAP, C-PAP (does NOT include inhalers)								
IN-HOME DIALYSIS								
TPN (Total Parenteral Nutrition)								
TRANSFUSIONS								
TRACHEOSTOMY CARE								
TUBE FEEDINGS								
ULCER – Stage 2								
ULCER – Stage 3 or 4								
URINARY CATHETER-RELATED SKILLED TASKS (irrigation, straight catheterizations)								
OTHER WOUND CARE (not catheter sites, ostomy sites, or IVs)								
VENTILATOR-RELATED INTERVENTIONS								
OTHER (specify):								

SKILLED THERAPIES: PT, OT, Speech. Other (specify). ☐ 5+ Days/Week ☐ 1-4 Days/Week
Comments:

Section 3: Planning Issues For Health

Priorities and Support Needs	**Comments:** What needs to be done, when, by whom
☐Adaptive Equipment ☐Community Doctor ☐Dentist ☐Evaluations (OT, Hearing, Vision, etc.) ☐Exercise ☐Medical Supplies ☐Preventative Health Care ☐Pharmacy ☐Pain Management ☐Specialist ☐Therapy ☐Other:	
Resources	**Comments:**
☐Own Equipment ☐Other:	

Section 4: Planning Issues for Housing

Priorities	**Comments:** What needs to be done, when, by whom
☐Access to Home ☐Access To Rooms ☐Appliances ☐Bathroom Modifications ☐Change Of Address ☐Equipment ☐Furniture ☐Independent Housing ☐Keys For Care Providers ☐Kitchen Modifications ☐Location ☐Pet Accommodations ☐Shared Housing ☐Subsidized Housing ☐Telephone ☐Utilities ☐Other:	
Resources	**Comments:**
☐Donated Funds ☐Donated Furniture ☐Independent Living Center ☐Own Furniture ☐Service Clubs (E.G., Kiwanis, Rotary) ☐Subsidy Programs e.g., LIHEAP, Section 8) ☐Other:	

Section 5: Planning Issues for Financial Matters

Priorities	**Comments:** What needs to be done, when, by whom
☐Credit History May Be Problematic ☐Current Bills/Debts That Require Action ☐Determine Amount And Sources Of Income ☐Develop A Budget ☐Eligibility For CalFresh ☐Establish Bank Account ☐Establish Direct Deposit ☐Money Management Services ☐Other:	
Resources	**Comments:**
☐Family Support ☐Other Pension ☐Personal Savings ☐Social Security ☐SSI ☐VA ☐Other:	

Section 6: Planning Issues for Independence/Self-Determination

Priorities	**Comments**: What needs to be done, when, by whom
Assistance With: ☐Back-Up Plan For Emergencies ☐Decision-Making ☐Emotional Support ☐Communication Equipment ☐Health Care Advocate ☐Support Group ☐Legal Advice ☐Living Will ☐Memory ☐Power Of Attorney ☐Record Keeping ☐Other:	
Previous Experience; contact With community agencies (e.g., IHSS, APS); nature of this experience:	
Resources	**Comments:**
☐Family ☐Friends ☐Independent Living Center ☐Religious/Spiritual Group ☐Social Clubs ☐Other:	

Section 7: Planning Issues for Social and Recreational Needs

Priorities	**Comments:** What needs to be done, when, by whom
☐Ethnic/Cultural Traditions ☐Future Events to Plan for (Birthdays, Holidays, Etc.) ☐Hobbies (Either To Maintain Or Develop) ☐Meet Neighbors ☐Private Time ☐Peer Support ☐Religious/Spiritual Affiliation ☐Phone Calls ☐Visits From Friends/Family ☐Other:	
Resources	**Comments:**
☐Family/Friends ☐Other (Specify): ☐Place Of Worship ☐Volunteer Opportunities ☐Other:	

Section 8: Planning Issues for Transportation

Priorities	**Comments**: What needs to be done, when, by whom
☐Mobility Training ☐Will Require Escort ☐Routine Transportation (e.g., Bus, Taxi, Dial-A-Ride) (Schedules, Tokens/Scrip) ☐Transportation From NF To New Residence (Self & Belongings) ☐Other:	
Resources	**Comments:**
☐Family ☐Friends ☐Own Vehicle ☐Public Program (e.g., Paratransit Discount) ☐Volunteer ☐Other:	