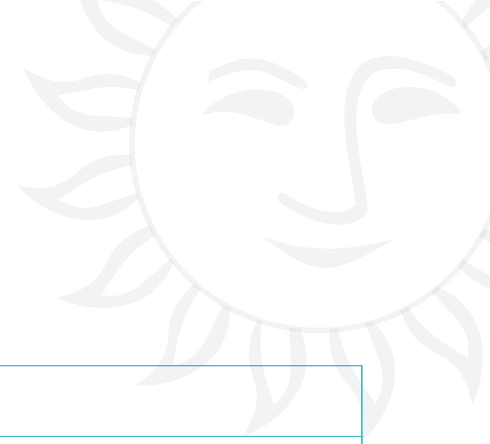

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Nursing Assessment for Home Care

Patient Information

Last Name First Name Middle Initial

Contact Person (Name & Relationship)

Contact Phone (Day-time)

Living Situation

Dwelling: ☐ Apartment ☐ House ☐ Other: Floor: # of Rooms Elevator: ☐ Yes ☐ No

Lives alone: ☐ Yes ☐ No Identify all individuals living in the home :

List the services, hours and days they are available and able to assist with care giving:

Hospitalization

Hospital Name

Hospitalized: From: To: Diagnoses:

Hospital Contact : Phone:

Impairments

Sensory	None	Partial	Total
1. Speech	☐	☐	☐
2. Sight	☐	☐	☐
3. Hearing	☐	☐	☐

Muscular/Motor	None	Partial	Total
1. Hand/Arm	☐	☐	☐
2. Upper Extremities	☐	☐	☐
3. Lower Extremities	☐	☐	☐

Cardiovascular / Respiratory

	None	Partial	Total
1. Respiratory	☐	☐	☐
2. Cardiac	☐	☐	☐
3. Circulatory	☐	☐	☐

Describe impact on functional ability

1. Does patient have history of tuberculosis? ☐ Yes ☐ No ☐ Pulmonary ☐ Extra pulmonary
2. Did patient complete therapy ☐ Yes ☐ No
3. Does patient currently have tuberculosis? ☐ Yes ☐ No ☐ Pulmonary ☐ Extra pulmonary
4. Is patient currently on tuberculosis prophylaxis? ☐ Yes ☐ No Hx of TB prophylaxis ☐ Yes ☐ No

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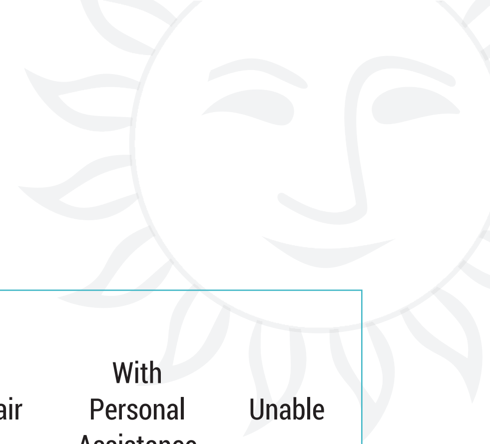

Identification of Service Needs

	Without Help	With Cane	With Walker	With Wheelchair	With Personal Assistance	Unable
Ambulate Inside	☐	☐	☐	☐	☐	☐
Ambulate outside	☐	☐	☐	☐	☐	☐
Get up from seated position	☐	☐	☐	☐	☐	☐
Get up from bed	☐	☐	☐	☐	☐	☐
Transfer to						
Commode	☐	☐	☐	☐	☐	☐
Wheelchair	☐	☐	☐	☐	☐	☐

	Indepen-dent	Partial Assist	Total Assist
Activities	☐	☐	☐
Turn & Position	☐	☐	☐
Mobility Assist	☐	☐	☐
ROM exercises	☐	☐	☐
Ambulation Assist	☐	☐	☐
Home making	☐	☐	☐
Vacuuming	☐	☐	☐
Dust/Damp Mop	☐	☐	☐
Kitchen cleaned	☐	☐	☐
Dishes	☐	☐	☐
Bathroom	☐	☐	☐
Make/Change Bed	☐	☐	☐
Empty commode	☐	☐	☐
Empty trash	☐	☐	☐
Laundry/client's home	☐	☐	☐
Laundry/Laundromat	☐	☐	☐
Wash stove top	☐	☐	☐
Clean refrigerator	☐	☐	☐
Dust	☐	☐	☐
Mirrors/Windows	☐	☐	☐
Other	☐	☐	☐
Errands	☐	☐	☐
Shopping	☐	☐	☐
Prescription pickup	☐	☐	☐

	Indepe-ndent	Partial Assist	Total Assist
Appt accompany	☐	☐	☐
Grocery shopping	☐	☐	☐
Cash-received	☐	☐	☐
Cash-returned	☐	☐	☐
Client Refused			
/client not home	☐	☐	☐
Personal Care	☐	☐	☐
Bath/Shower	☐	☐	☐
Tube/Bed	☐	☐	☐
Hair Care	☐	☐	☐
Shampoo	☐	☐	☐
Shave	☐	☐	☐
Mouth/Denture Care	☐	☐	☐
Oral Care-swab/brush	☐	☐	☐
Assist with Dressing	☐	☐	☐
Lotion/Skin barrier	☐	☐	☐
Help with toileting	☐	☐	☐
Nail Care	☐	☐	☐
Wash/rub back	☐	☐	☐
Check for skin-			
breakdown	☐	☐	☐
Catheter Care	☐	☐	☐
Elimination assist	☐	☐	☐
Equipment care	☐	☐	☐

	Indepen-dent	Partial Assist	Total Assist
Check Swelling	☐	☐	☐
Abdomen/None	☐	☐	☐
Hands/Feet	☐	☐	☐
Legs(R/L)	☐	☐	☐
Nutrition	☐	☐	☐
Diet Order	☐	☐	☐
Food Allergies	☐	☐	☐
Limit/Enc Fluids	☐	☐	☐
Meals Prep	☐	☐	☐
Feeding/Serving	☐	☐	☐
BP/BS check reminders	☐	☐	☐
Medication Reminders	☐	☐	☐

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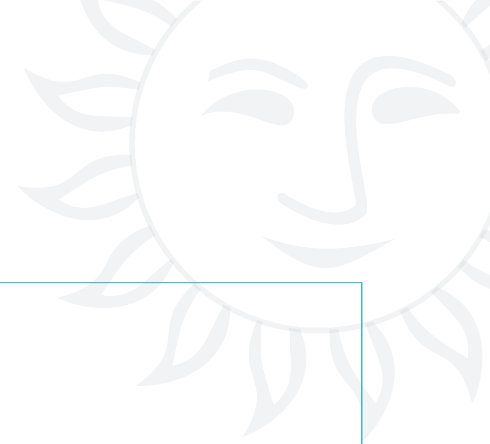

Certification

This assessment is based on personal observation of the patient. ☐ Yes ☐ No

This assessment is based on information relayed to me by: ______________________

Nurse Name ______________________ **Date** ______________

Nurse Signature ______________________

Is any other agency/vendor providing services in the home to the patient? ☐ Yes ☐ No

If Yes, Agency Name : Services:

Have all home care Insurance benefits been exhausted? ☐ Yes ☐ No