NURSING HEALTH AND SAFETY ASSESSMENT

FORM B

Section I: Identifying Information

1. Name: Age: DOB (mm/dd/yyyy): Male ☐ Female ☐

Address:

City State Zip Code

2. Name of Evaluator: Date of Report (mm/dd/yyyy) :
3. Purpose of Evaluation: ☐ Annual ☐ Change in Status ☐ Other (specify)
4. Living Situation: ☐ Waiver ☐ Family Home ☐ Host Home ☐ Other (specify)
5. Race: ☐ African American ☐ Asian ☐ Hispanic ☐ White ☐ Native American ☐ Other (specify)

6. **DSM AXIS**	***CURRENT DIAGNOSES***
I	
II	
III	

7. Communication: ☐ Verbal ☐ Sign ☐ Assistive Technology ☐ Nonverbal (Comments:)
8. Ambulation Status (describe):
9. Adaptive equipment: ☐ None ☐ (If yes, *list all*) _____

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10. Medical equipment: (*include glucose monitoring, CPAP, respiratory supplies, medical alert device, etc*) ☐ None
    Indicate type and frequency of use: _____
    Is the individual able to utilize equipment independently? ☐ With verbal prompts ☐ Other (specify) _____

11. History of Falls: ☐ No ☒ Yes (specify frequency & follow-up) _____

Section II: Brief Health History

12. Hospitalizations and emergency room visits during the past year: (Dates and Reasons)

13. Illnesses during the past year:

14. **Significant Family History**
    - Information obtained from health record ☐ Yes ☐ No
    - Information obtained from family member: ☐ Yes ☐ No
      (If Yes, give name:)
    - Relationship to individual:
    - Date (mm/dd/yyyy):

15. Family History of Cardiac Problems/Hypertension

16. Family History of Diabetes

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17. Family History of Seizures

18. Family History of Cancer

19. Family History of Known Genetic Disorders

20. Other Family History

Section III: Health Data

21. **Allergies**:

☐ Food ☐ Environmental ☐ Medication Reaction ☐ No Known Allergy

If any reaction, identify antigen & clinical reaction: _____

EpiPen: Yes ☐ No ☐

22. **Current Medical Information:**

Medical Problem (s) Requiring Nursing Monitoring	Date Diagnosed (mm/dd/yyyy)	Date Resolved (mm/dd/yyyy)
Date of last evaluation and comments:		

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****INSTRUCTIONS: Document findings WNL (within normal limits/negative); NWNL (not within normal limits). Further explanation is needed for all NWNL findings.**

System	WNL	NWNL	Description
23. **Emotional Mental Status**			**(Indicate frequency,duration,precipitators)**
1. Functional Orientation	☐	☐	
2. Nervousness/anxiety	☐	☐	
3. Sadness/loneliness	☐	☐	
4. Fearful/withdrawn	☐	☐	
5. Irritable/angry	☐	☐	
Date of last psychological exam (mm/dd/yyyy): ☐ None indicated Results: _____			
Date of last psychiatric exam(mm/dd/yyyy) : ☐ None indicated Results: _____			
24. **Maladaptive Behavior**			**(Indicate frequency,duration,precipitators)**
1. Aggressive/ Assaultive	☐	☐	
2. Destructive	☐	☐	
3. Self-injurious	☐	☐	
4. PICA	☐	☐	
5. Running away	☐	☐	
6. Verbal abuse	☐	☐	
Psychotropic medications: ☐ Yes ☐ No If Yes, date of consent, provided by whom? Date of last Behavior Support Plan (BSP) (mm/dd/yyyy): ☐ None indicated Targeted behaviors: Date of consent for BSP (mm/dd/yyyy):			

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25. **Consent Procedures**

Individual has the capacity to make medical decisions: ☐ Yes ☐ No	Individual has a substitute health care decision maker: ☐ Yes ☐ No
To obtain consent contact: Name: Phone:	
In a medical emergency two physicians may agree to proceed with medical intervention.	
Advance Directives/DNR None ☐	

26. **Individual's Health Concerns**

Individual's Perspective: _____

Care Provider's Perspective (give name/title): _____

Family Member's perspective (give name/relationship): _____

27. **Seizure Disorder**: Type

Frequency

N/A ☐

Describe individual's awareness of seizure disorder and coping strategies: _____

28. Current Medications:

Date Started (mm/dd/yyyy)	Medication	Dosage	Times	Route	Reason	Date to be Discontinued (mm/dd/yyyy)

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29. Medication regimen (indicate one): ☐ no changes over past 3 months
☐ changes over past 3 months
(Describe changes: _____)

30. Is self administration program utilized for any of the above listed medications? ☐ Yes ☐ No
If Yes, is the program for all medications? ☐ Or, some medications? ☐
If some, then list the medications: _____
Date of most recent self administration assessment (mm/dd/yyyy):

31. Vital Signs & Nutritional Issues

Date: / / B/P: T: P: R: Ht: Wt:
Ideal Body Weight: ☐ Not determined
Diet:
Comments:

***Section III: Health Skills Assessment**

Individual	Yes	No	Comments
32. Participates in the selection of health care providers as possible	☐	☐	

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33. Contacts primary care provider independently for appointments, concerns	☐	☐	
34. Requires assistance to contact primary care provider	☐	☐	
35. Understands own diagnoses and health status (*specify*) ☐ all ☐ some	☐	☐	
36. Understands prescribed treatments ☐ all ☐ some	☐	☐	
37. Requires assistance to understand treatments (*if yes, specify all who assist*) ☐ Staff ☐ Nurse ☐ Family ☐ Guardian	☐	☐	
38. Complies with health recommendations and treatment to promote optimal health	☐	☐	
39. Understands impact of non-compliance with health recommendations/treatments	☐	☐	
40. Receives training/counseling about non-compliance with health issues (*if yes, specify from whom*) ☐ Support Team ☐ MD ☐ RN ☐ Other	☐	☐	
41. Attends medical appointments independently (*if no, specify type of assistance needed*) ☐ Transportation ☐ Staff to accompany ☐ Other	☐	☐	
42. Promptly, appropriately, and accurately reports abnormal health conditions (*if yes, specify to whom reports*) ☐ Staff ☐ Family/Guardian ☐ Primary Care Provider	☐	☐	
43. Knows how to use 911 to contact emergency personnel	☐	☐	
44. Has emergency device to contact assistance (*specify)*	☐	☐	

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45. Knows how to evacuate self from danger: fire, intruders, etc.	☐	☐	
46. Performs first aid techniques: control bleeding, clean wound, apply band-aid	☐	☐	
47. Participates in exercise (*specify)*	☐	☐	
48. Drinks alcohol? If yes, describe amount/frequency)	☐	☐	
49. Knows and understands risks and outcome of alcohol abuse	☐	☐	
50. Uses street drugs? (If yes, give type/frequency)	☐	☐	
51. Knows and understands risks and outcome of drug abuse	☐	☐	
52. Uses cigarettes ☐ chewing tobacco ☐ (If yes, give amount/frequency)	☐	☐	
53. Knows and understands risks and outcome of tobacco use	☐	☐	

***Maximizing life potential**

Category: Sexuality	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and Unpredictable	Comments
54. Knows, understands sexual anatomy of males/females	☐	☐	☐	☐	
55. Knows, understands and practices safe sexual behaviors	☐	☐	☐	☐	
56. Is sexually active?	☐	☐	☐	☐	

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57. Independent in fulfilling individual need to express sexuality through personal presentation, relationships or activities.	☐	☐	☐	☐	
58. Able to express sexuality independently. Requires some assistance with facilitating privacy, relationship opportunities or personal presentation.	☐	☐	☐	☐	
59. Needs assistance to express sexuality for e.g. personal presentation. Enjoyment of desired relationships requires management of the environment.	☐	☐	☐	☐	
60. Needs staff assistance in establishing appropriate environment to fulfill sexual needs and expression of sexuality. May need specialist assessment, such as from a psychosexual therapist.	☐	☐	☐	☐	
61. Exhibits significant challenging behavior in respect of sexuality. May need therapeutic intervention and/or close supervision or support.	☐	☐	☐	☐	

***Prevention and relief of distress (Choose one of the following numbers and prompt levels)**

Category: Pain Control	**Independent**	**Verbal Prompts Needed**	**Assistance Needed**	**Completely Dependent**	**Comments**
62. Pain free. Self caring in the management of pain.	☐	☐	☐	☐	

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63. Experiences pain which they are able to manage and can ask when treatment is required.	☐	☐	☐	☐	
64. Experiences regular or protracted pain which cannot be managed unsupported, although needs can be expressed. Needs assistance, supervision or support in controlling the pain.	☐	☐	☐	☐	
65. Able to express verbally protracted pain, but unable to specify the type of pain or its effects. Requires a range of interventions to control pain.	☐	☐	☐	☐	
66. Unable to describe needs in respect of pain. The level of pain experienced can only be seen through behavior, facial or bodily expression and emotional state. Requires complex interventions.	☐	☐	☐	☐	

67**. Health Passport**

How to use the Health Passport: ☐ was reviewed ☐ was not reviewed

Comments: _____

68**. Health Form 1**

All laboratory tests and screenings that are recommended on the Health Form 1 based on age/gender have been reviewed:

☐ Yes ☐ No

List any tests or screenings that are currently pending: _____

Within the next 12 months, the need for the following tests will be discussed with the primary care physician: _____

69. **Immunization Status:**

Immunizations/Vaccinations	
Date of last TETANUS (mm/dd/yyyy):	Date of last INFLUENZA (mm/dd/yyyy):

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Date of PNEUMOVAX (mm/dd/yyyy):	Date of PPD/Chest X-Ray (mm/dd/yyyy): Results:
HEPATITIS B Surface Antigen:	HEPATITIS B Immunity:
Other: (Give name and date)	Date HEP B Vaccine Series Completed (mm/dd/yyyy):

70. **Summary of Findings:**

For information regarding specific areas of concern and expected outcomes, see the attached Health Management Care Plan.

_____ _____

Name of Evaluator & Title Signature of Evaluator

** Adapted from Nursing Assessment and Older People (2004). Royal College of Nursing, London.*

*** Adapted from CT Department of Developmental Services, Nursing Health & Safety Assessment, 2006.*

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