RIGHT ACCORD
Private Duty-Home Health Care

Address: 3900 Clark Road Suite B5, Sarasota, FL 34233
Telephone: 941.366.0801 Email: management@rightaccordhealth.com

Client Assessment Form

Date:

First Name:	**Middle Name:**	**Last Name:**
Phone number:	**Date of Birth:**	**Gender:** **Weight:**
Email address:	**Start of Service:**	**End of Service:**

Address:	**Billing address:**

Emergency contact/next of kin: **Relationship:** **Date of birth:** **Phone number: (h)** **(c)** **Email address:**	**Emergency contact/next of kin:** **Relationship:** **Date of birth:** **Phone number: (h)** **(c)** dff **Email address:** fdgd

Supervisor:	**Ambulatory: YES** ☐ **NO** ☐
Referred by:	**Client type: Private Pay by client:** ☐ **Private pay by other:** ☐ **Insurance company:** ☐
Physician Name: **Phone number(s):**	**Physician address:** **Fax number:**

Principal Diagnosis/Medical History:	**DNR:** **YES** ☐ **NO** ☐

MEDICAL HISTORY:

ALZHEIMER's ☐ **ARTHRITIS** ☐ **BLIND** ☐ **BP ISSUES** ☐ **BREATHING ISSUES** ☐ **CANCER** ☐ **CHRONIC PAIN** ☐ **DEMENTIA** ☐

DIABETES ☐ **FALLS** ☐ **HEARING ISSUES** ☐ **HEART ISSUES** ☐ **INCONTINENT** ☐ **MEMORY ISSUES** ☐ **PARALYSIS** ☐

SPEAKING ISSUES ☐ **STROKE** ☐ **TREMORS** ☐ **VISION ISSUES** ☐ **WOUNDS** ☐ **OTHER: -**

_____

Assessed by: (print name)	**Date:**

MOBILITY **INDEPENDENT** ☐

Assist with ambulation ☐ **Assist with transfers** ☐ **Bed/Chair only** ☐ **ROM exercises** ☐ **Standby assistance** ☐

VISION LOSS **NOT APPLICABLE** ☐

Right eye ☐ **Left eye** ☐ **Peripheral only** ☐ **Wears glasses** ☐ **Clean glasses** ☐ **PARTIAL VISION LOSS** ☐

HEARING

Hard of hearing ☐ **Wears hearing aid** ☐ **Is deaf** ☐ **NOT APPLICABLE** ☐

DIET **INDEPENDENT** ☐

Normal ☐ **Diabetic** ☐ **Low Sodium** ☐ **Liquid only** ☐ **Feeding assistance** ☐ **Meal preparation: Breakfast** ☐ **Lunch** ☐ **Dinner** ☐

BATHING **INDEPENDENT** ☐ **A.M.** ☐ **P.M.** ☐

Partial ☐ **Complete** ☐ **Tub** ☐ **Shower** ☐ **Sponge bath** ☐ **Sink** ☐ **Other:** _____

SKIN CARE **HAIR CARE** **INDEPENDENT** ☐

Moisturizer ☐ **Powder** ☐ **INDEPENDENT** ☐ **Wash and dry** ☐ **Wash and set** ☐ **Brush and comb** ☐

ORAL CARE **NAIL CARE** **INDEPENDENT** ☐

Brush and floss ☐ **Denture care** ☐ **INDEPENDENT** ☐ ☐ ☐ **lean** **File** ☐ **l care** ☐ **olish**

SHAVING

Face ☐ **Axilla** ☐ **Legs** ☐ **Electric razor** ☐ **Safety** ☐ ☐

INDEPENDENT

DRESSING **INDEPENDENT** ☐ **WEIGHING** **INDEPENDENT** ☐

Self dress ☐ **Help select clothes** ☐ **Assist with dressing** ☐ **Weigh client** ☐ **Frequency** _____

TOILETING

Bathroom ☐ ☐**dpan** ☐ **Ur** ☐ ☐**mmode** **C** ☐**ge diapers**

INDEPENDENT

TRANSPORT

Has own car for caregiver use ☐ **Drives self** ☐ **Unable to drive** ☐ **Use of Caregiver's car** ☐ **Transport Waiver on file** ☐

ASSISTANCE WITH MEDICATION

Yes ☐ ☐ **No** **Assistance with Medication Informed Conser** ☐ **n file**

HOUSEKEEPING

None ☐ ☐ **Light** ☐ **Normal** **Special Instructions:** _____

FUNCTIONAL LIMITATIONS

AMPUTATION	☐		**PARALYSIS**	☐		**LEGALLY BLIND**	☐	
INCONTINENCE	☐		**ENDURANCE**	☐		**DYSPNEA**	☐	
CONTRACTURE	☐		**AMBULATION**	☐		**OTHER LIMITATION**	☐	
HEARING	☐		**SPEECH**	☐		**DESCRIPTION:**	☐	

ACTIVITIES PERMITTED

COMPLETE BEDREST	☐		**PARTIAL WEIGHT BEARING**	☐		**WHEELCHAIR**	☐
BEDREST BRP	☐		**INDEPENDENT AT HOME**	☐		**WALKER**	☐
UP AS TOLERATED	☐		**CRUTCHES**	☐		**NO RESTRICTIONS**	☐
TRANSFER BED/CHAIR	☐		**CANE**	☐		**OTHER**	☐
EXERCISES PRESCRIBED	☐			☐		**DESCRIPTION:**	☐

MENTAL STATUS

Oriented ☐ **Forgetful** ☐ **Disoriented** ☐ **Agitated** ☐ **Comatose** ☐ **Depressed** ☐ **Lethargic** ☐ **Other: _____**

PROGNOSIS

POOR ☐ **GUARDED** ☐ **FAIR** ☐ **GOOD** ☐ **EXCELLENT**

DME and SUPPORTIVE DEVICES: **YES** ☐ **NO** ☐	**SAFETY MEASURES:** FALL PRECAUTIONS	**PETS?:** **YES** ☐ **NO** ☐ **CAT** ☐ **DOG** ☐ **TYPE: _____**
NUTRITIONAL REQUIREMENTS:	**ALLERGIES:** **YES** ☐ **NO** ☐	**SERVICES REQUESTED:**

SPECIAL INSTRUCTIONS:

_____

_____

_____

_____

_____

_____

_____

Assessed by:

Signature: _____ **Date: _____**
(Assessed by)

****

Authorized by:

RN Name: _____
(printed)

RN Signature: _____ **Date: _____**
(signature)