MAS RN ASSESSMENT

[The MAS RN is responsible and accountable for the completion of a comprehensive assessment and evaluation of patients' nursing care needs ABN 610-x-7-.06(3)]

□ Initial □ Annual □ Status Change

Person's Name					Case #/SS#
Date	Facility Name				
DOB	Gender: (✓ One) ☐ Male ☐ Female	Age	Race	Date of Admission/ Readmission (circle one)	Time of Admission (✓ One) ☐ AM ☐ PM
Transported By: ☐ Car ☐ Van ☐ Ambulance ☐ Other _____		Received From:		Accompanied By:	Relationship

MEDICAL HISTORY

Name of PCP/CRNP(s): (primary care provider)			
Phone #s:	( )		( )
Other Physicians:			
Date of Last PCP Visit:		**Date of Last Physical Exam**	
		Name of PCP performing exam	
Baseline Data	**BMI**	**WT HT Waist Circumference**	
Date of Last TB Skin Test or CXR (IF INDICATED)		**Result**	
Vital Signs	T _____ P _____ R _____ BP _____ Arm: ☐ R ☐ L	O2 SAT_____	FSBS _____ (IF APPLICABLE)
Pregnant?	☐ Yes ☐ No □ N/A	Last Menstrual Period	□ N/A
	Breast Discharge □ **Yes** □ **No** □**N/A**	**Changes in Libido** □ **Yes** □ **No** Comments:	
	Date of Last Mammogram **Results**	**PSA Date _____ Results _____ □ N/A** Erectile/Ejaculatory Problems □ Yes □ No □N/A	
Allergies	☐ None □ EpiPen Required ☐ Medication(s) _____ ☐ Food(s) _____ ☐ Other (Seasonal? Symptoms?) _____		

Pain	☐ None				
	Location(s)				
	Frequency	☐ Daily	☐ Daily/Intermittent	☐ Constant	☐ Other
	Intensity _____ (state # on 10 scale)	☐ Mild	☐ Distressing	☐ Severe	☐ Unbearable
	Pain on Admission	☐ No	☐ Yes *(If yes explain)*		

Special Treatments/Procedures/ Equipment (List all including purpose):	☐ None
Past Surgeries/Implants (list all including year and location):	☐ None
Past Psychiatric/Medical Hospitalizations (List all including year/location/reason):	☐ None

FAMILY / RELATIONSHIPS

Marital Status	Children	Parents	Siblings	Significant Others
☐ Married ☐ Single ☐ Divorced ☐ Other	☐ Yes Number: ____ ☐ No	Mother ☐ Alive ☐ Deceased Father ☐ Alive ☐ Deceased	☐ None ☐ Yes Number _____ # Alive _____ # Deceased _____	Legal Guardian ☐ Yes ☐ No Name _____ Friend(s) ☐ Yes ☐ No ☐ Other

RELIGIOUS/SPIRITUAL/CULTURAL	
Religious Affiliation	□ **None**
Attend Church?	☐ Yes ☐ No
Cultural/Ethnic Practices That Impact Care/Teaching (List)	□ **None**

CURRENT STATUS

PHYSICAL LIMITATIONS (Muscle/Skeletal System)

□ **NONE**	**Site**	**Degree**
Paralysis/paresis		
Contracture(s)		
Congenital Anomalies		
Prosthesis		
Other		

FUNCTIONAL ABILITY

AMBULATION	WEIGHT BEARING	TRANSFERS	SUPPORTIVE DEVICES
☐ Independent	☐ Full Weight	☐ Independent	☐ Elastic Hose
☐ 1 Person Assist	☐ Partial Weight	☐ 1 Person Assist	☐ Hand Rolls
☐ 2 Person Assist	☐ Non-Weight Bearing	☐ 2 Person Assist	☐ Sheepskin
☐ With Device *(name)* _____		☐ Total Dependence	☐ Other *(list)* _____
☐ WC only			_____
☐ WC Propels Self			_____

GENERAL SKIN CONDITION: *(Check all that apply)*

	SITE		SITE
☐ Dry		☐ Oily	
☐ Edematous		☐ Cyanotic	
☐ Pale		☐ Warm	
☐ Moist		☐ Cold	
☐ Reddened		☐ Jaundiced	
☐ Ashen		☐ Other	

Hearing	R	L	Vision	R	L	Speech	
☐ Adequate			☐ Adequate			☐ Clear	
☐ Poor			☐ Poor			☐ Aphasic	
☐ Deaf			☐ Blind			☐ Other	
☐ Hearing Aid			☐Glasses/Contacts			Language:	

Oral	Eating/Nutrition	Sleep	Bathing/ Grooming	Indep	Assist	Dep
☐Own Teeth *(Note condition)* **DENTURES** ☐Partial ☐ Full ☐Upper ☐Lower **Fit** ☐Yes ☐ No	☐ Independent ☐ Needs Assist ☐ Dysphasic (reason) _____ ☐ Adaptive Equipment *(type)* _____ ☐Diet (Consistency/limitations)	Usual Bedtime _____ Usual Arising Time _____ **Nap** ☐Yes ☐ No Frequency/ Length	☐Tub	□	□	□
			☐Shower	□	□	□
			☐Bed Bath	□	□	□
			Oral Hygiene	□	□	□
			Shave	□	□	□
			Shampoo	□	□	□
			Grooming	□	□	□
			Dressing	□	□	□

BOWEL AND BLADDER EVALUATION (GENTIAL/URINARY)

Bowel Continent Other:		Bladder Continent Other:		Frequent Constipation	
☐Y	☐N	☐Y	☐N	☐Y	☐N
How managed?		How managed?		How managed?	

PERSONAL/FAMILY HISTORY

- Diabetes (Endocrine): ☐ No ☐ Self ☐ Family
- Cardiovascular Disease: ☐ No ☐ Self ☐ Family
  ☐ Heart Attack ☐ Stroke ☐ Other _____
- High Cholesterol: ☐ No ☐ Self ☐ Family

PSYCHOSOCIAL FUNCTIONING

Oriented	☐Y ☐N	☐Person ☐Place ☐Time ☐Situation ☐Facility
General Appearance	☐Dressed/groomed appropriately for age/sex/situation ☐Disheveled ☐Pale ☐Emaciated ☐Sad ☐Happy	
Level of Consciousness/ Behavior	☐ Alert ☐ Lethargic ☐ Expressionless ☐ Cooperative ☐ Rigid/Tense ☐ Other *(explain)*	☐ Responsive ☐ Combative ☐ Tics/Tremors ☐ Hostile ☐ Compulsive
		☐ Hyperactive ☐ Joyful ☐ Pacing ☐ Calm
Speech	☐ Talkative ☐ Nonverbal ☐ Loud ☐ Other *(explain)*	☐Forced ☐Slurred ☐Illogical
		☐Pressured/Excessive ☐Impediment ☐Monosyllabic
Affect/Mood	☐ Appropriate ☐ Anxious ☐ Angry ☐ Friendly ☐ Other *(explain)*	☐ Depressed ☐ Guarded ☐ Cooperative
		☐ Elated ☐ Flat ☐ Uncooperative
Thoughts	☐ Normal ☐ Wandering ☐ Illusions ☐ Homicidal ☐ Other *(explain)*	☐ Guarded ☐ Disorganized ☐ Delusional ☐ Suicidal
		☐ Flighty ☐ Paranoid ☐ Hallucinations
Memory	☐ Remote Memory (past) ☐ Recent Memory	☐ Delayed Recall (repeat after 5 minutes) ☐ Attention Level (ability to concentrate)
Insight	☐ Good ☐ Fair ☐ Poor *(What is causing your problem? What causes you to be here today?)*	
Judgment	☐ Good ☐ Fair ☐ Poor (What would you do if you ran out of meds?)	

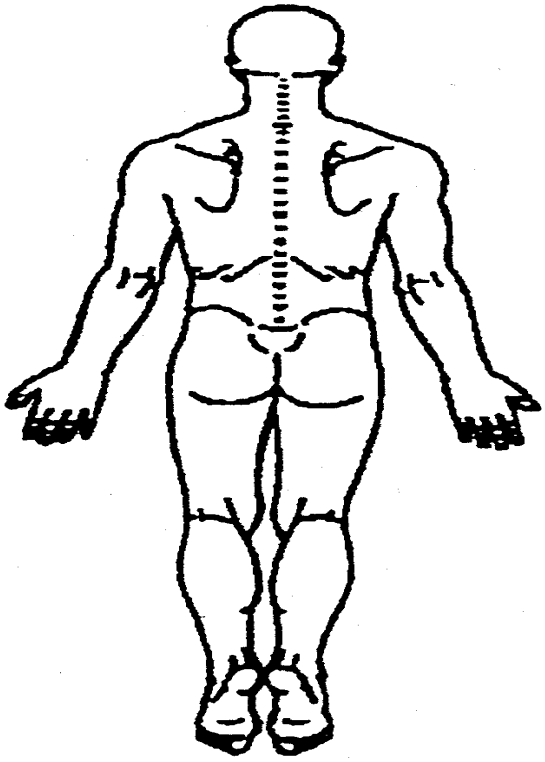
Personal Habits	Smokes Cigarettes/Cigar/Pipe ☐ Yes / ☐ No Amt./day	Drinks Alcohol ☐ Yes / ☐No Amt./day	Illegal Drug Use ☐ Yes / ☐ No Type/Freq
	Have you received assistance to stop smoking? ☐ Yes / ☐ No If yes, when/where?	Have you received treatment for alcohol? ☐ Yes / ☐ No If yes, when/where?	Have you received treatment for drug misuse/abuse? ☐ Yes / ☐ No If yes, when/where?
Family Support	☐ Good ☐ Fair ☐ Poor	**Family Relationship**	☐ Good ☐ Fair ☐ Poor

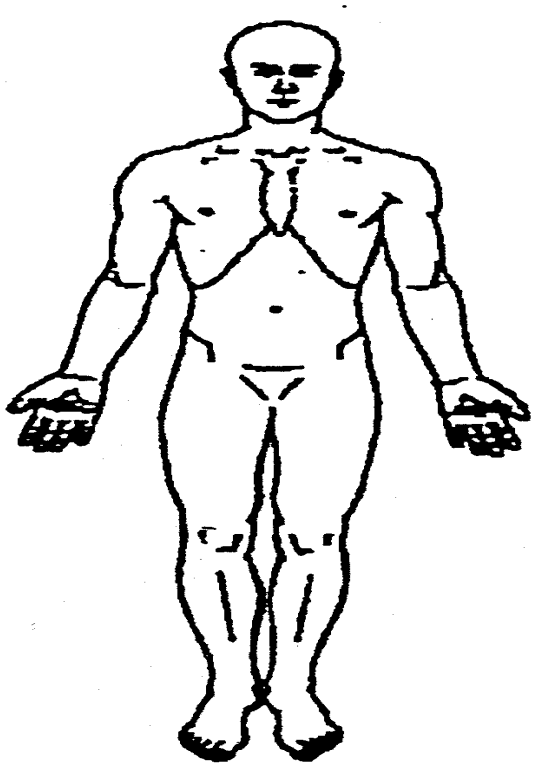
CURRENT MEDICATIONS				
NAME	**DOSE**	**FREQ**	**DIRECTIONS FOR USE/ ROUTE**	**REASON**
AIMS COMPLETED? □ **Yes** □ **No** □ **N/A** **FALLS COMPLETED?** □ **Yes** □ **No** □ **N/A**				**(File in clinical record)**

ATTACH ADDITIONAL SHEET IF NEEDED

MAS LPN SIGNATURE_____

DATE: _____





REVIEW OF SYSTEMS: (Skin, HEENT, Cardio, Respiratory, Gastrointestinal, Genitourinary, musculoskeletal, Psychosocial, Nervous, Blood)	
SKIN: □ Warm □ Dry □ Intact	Color:
Comments:	
HEENT (Head, Eyes, Ears, Nose, Throat)**:** □ Symmetric □ Pupils equal/reactive □ No drainage/inflammation	
Comments:	
Cardiopulmonary: □ Heart beat regular □ No edema □ Pulses present (carotid, radial, pedal)	
Comments:	
Respiratory: □ Lung sounds clear □ cough □ SOB □ Reg Rate & Rhythm	
Comments:	
GI: □ Abd soft □ Bowel sounds present X 4 quads □ No distention □ Hx of GERD	
Comments:	
GU: □ "No pain/burning on urination" □ "No lesions" □ "No drainage" □ Breast WNL (Last mammogram _____)	
Comments:	
Musculoskeletal: □ Ambulatory □ Normal gait □ Normal posture □ No abnormal movements □Devices (list)	
Comments:	
Neuro/Psychosocial: □ No hx of Seizures □ A & O X3 □ No maladaptive behaviors	
Comments:	
Blood: □ No blood disorders □ Lab work done within last 12 months □ Lab WNL	
Comments:	
MAS RN SIGNATURE	**DATE**

Based on the problems listed the level of *nursing/medical care required* is:
(Select all that apply)

☐	**Skilled Nursing Only**
☐	MAC Worker Assistance with MAS Nurse Supervision 24/7
☐	Psychiatric status monitoring (state frequency)
☐	Medical/physical status monitoring (state frequency)
☐	Referral to: ☐PCP ☐Dentist ☐Optometrist ☐Other_____

Based on the problems listed and the level of nursing/medical care required, the following *nursing interventions will be implemented* directly or via delegation (SELECT ALL THAT APPLY. ADD ADDITIONAL INTERVENTIONS AS NEEDED

□	Skilled Nursing □ 24 hours □ Intermittent (state frequency)
□	MAS Nurse Supervision of MAC Worker
□	Fall Assessment (state frequency)
□	Choking Prevention/Assist with meals
□	I & O (state frequency)
□	T/P/R/BP/Wt. (state frequency)
□	Assisted ambulation/mobility/transfer
□	Assisted toileting/bathing
□	Monitor skin condition (state frequency)
□	Assisted communication
□	Lab (state frequency)_____ Date Due
□	Referral to service not provided by agency (List appointments made below)
	Appts:
□	MAS RN Care Plan(s) Completed
□	Assessment of ability to self-medicate completed (NDP 5) *Filed in clinical record*
	Other (Explain)

NAME _____ DATE _____ TIME _____ A/P

MAS RN SUMMARY OF ASSESSMENTS

_____

_____

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_____

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_____

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_____

_____

_____

MAS RN SIGNATURE/CREDENTIALS: _____

DATE: _____

RN assessment is completed/updated annually. Agency may use their own form, but the form is REQUIRED to have all the components of NDP 8