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| **CLIENT NAME:** |  | **ASSESSMENT DATE:** |  |

**SOC Human Systems Review**

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| **Vitals** | | | | | | | | | |
| **Temperature:** | | **Pulse:** | | | **Respiration:** | | | **Blood Pressure:** | |
| **Height:** | | **Weight:** | | | | **Recent Gain/Loss? Yes**  **No**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lbs** | | | |
| **Assistive Devices Used (Select all that apply)** | | | | | | | | | | |
| Glasses | Hearing Aid(s) | | | Dentures | | | Oxygen | | Dressings | |
| Walker | Wheelchair | | | Electric Cart | | | Cane | | Other: \_\_\_\_\_\_\_\_ | |
| **Health History** | | | | | | | | | | |
| **Primary Diagnosis:** | | | | | | | | | | |
| **Secondary Diagnoses:**  **Recent Health Changes:** | | | | | | | | | | |
| **Allergies: ( Medications/Foods/Environmental)** | | | | | | | | | | |
| **History of Falls:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 12months \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6 months \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3 months** | | | | | | | | | | |
| **Number of ER Visits in the past 12 months:** | | | **Recent Hospitalizations:** | | | | | | | |
| **Vaccination Status:**  Pneumonia vaccination received Yes  No  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Flu vaccination received Yes  No  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **TB Status (if known):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Any recent exposure to Communicable disease?** Yes  No | | | | | | | | | | |
| **History of: MRSA**  Yes  No **VRE**:  Yes  No **C-Diff**:  Yes  No **Hepatitis**:  Yes  No  **History of : Cancer** | | | | | | | | | | |
| **Other medical services involved (home care, social work, medical supplies etc.):** | | | | | | | | | | |
| **Family/Social Supports:** | | | | | | | | | | |

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| **Human Systems Review** | | |
| **Sensory and Communication** | | |
| **Problem** *(Select all that apply)* | | **Assessment** |
| **Vision**  Glaucoma  Cataracts  Surgery  Macular Degeneration  Legally Blind  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Right Eye  Left Eye  Wear Glasses  For reading  all the time |
| **Hearing** | | Hearing Aids Yes  No  Refuses |
| **Smell** | |  |
| **Communication** | | Aphasia Yes  No  Primary Language English  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other: Taste/ Temperature Sensation** | |  |
| **Mobility** | | |
| **Problem** *(Select all that apply)* | | **Assessment** |
| Tremor  Ataxia  Contractures  Amputation  Fracture  Other: \_\_\_\_\_\_\_\_ | | Gait/ Balance Normal  Balance problem with ambulation  Decreased muscular coordination  Unstable Gait Pattern  Immobile (bed or WC bound)  Use of Devise:  Cane  Walker  Wheelchair  Sit to Stand  Hoyer Lift  High Fall Risk  Yes  No |
| **Skin Integrity** | | |
| **Problem** *(Select all that apply)* | | **Assessment** |
| Rash  Wounds  Skin Tears  Itching  Cellulitis  Easily bruises  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Endocrine** | | |
| **Problem** *(Select all that apply)* | **Assessment** | |
| Thyroid Disorder:  Hypo  Hyper  Diabetes  Last A1C:\_\_\_\_\_\_\_\_\_\_\_\_  Liver Disease  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Insulin  Yes  No Oral  Yes  No Diet Controlled  Yes  No  Blood Glucose Monitoring:  Independent  Assistance  Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Normal Range: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parameters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Neurological** | |
| **Problem** *(Select all that apply)* | **Assessment** |
| Stroke/ TIA’s  Paralysis  Multiple Sclerosis  Parkinson’s  Neuropathy: Diabetic Vascular  Seizures  Headaches  Other: \_\_\_\_\_\_\_\_\_\_\_\_ | Weakness; Right Side  Left Side  Upper Extremities  Lower Extremities  Paralysis: Right Side  Left Side  Upper Extremities  Lower Extremities  Weight bearing status: Full  R  L  Weak  R  L  Upper Extremity Strength: Full  R  L  Weak  R L |
| **Gastrointestinal** | |
| **Problem** *(Select all that apply)* | **Assessment** |
| Heartburn  Gastric Reflux  Nausea/Vomiting  Constipation  Diarrhea  Bowel Incontinence  Ulcer  G Tube  J Tube  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Nutritional Status** | |
| **Problem** *(Select all that apply)* | **Assessment** |
| Difficulty Chewing  Pain in mouth/teeth/gums  Denture Fit  Periodontal disease  Issues with tongue  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Appetite:  Fluid Intake:  Nutritional Supplement: Yes  No  Intake of Caffeine:  Intake of Alcohol: | Good  Fair  Poor  NPO  Good  Fair  Poor  NPO  \_\_\_\_\_\_\_\_\_\_\_\_cups per day  \_\_\_\_\_\_\_\_\_\_\_\_drinks per day/ week/ month |
| Sleep Pattern: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hours per night  Awake at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_am Bedtime at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_pm |
| **Cardiovascular/Circulatory** | |
| **Problem** *(Select all that apply)* | **Assessment** |
| Blood Pressure  High  Low  Atrial Fibrillation  Chest Pain  Heart Attack  Pacemaker  Edema:  Heart Disease  CHF  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Genitourinary** | |
| **Problem** *(Select all that apply)* | **Assessment** |
| Urinary Incontinence  Partial  Total  HX UTI’s  Catheter:  Yes  No  Other \_\_\_\_\_\_\_\_\_\_\_\_\_ | Voiding Pattern:  Who is responsible for managing catheter and supplies: \_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( Add to ITP) |
| **Respiratory** | |
| **Problem** *(Select all that apply)* | **Assessment** |
| Shortness of Breath  Chronic Lung Disease  CPAP/ BiPAP  Cough  Pneumonia  Emphysema  Smoker/History of Smoking  Asthma  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Lung Sounds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Oxygen Use:  Yes  No:  Reason for use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Liters per minute \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hour use per day  Oxygen supply Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CPAP/ BiPAP Supply Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who is responsible for monitoring use and ordering supplies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( Add to ITP) |
| **Musculoskeletal** | |
| **Problem** *(Select all that apply)* | **Assessment** |
| Neuropathy  Fractures  Arthritis  Osteoporosis  Back Problems  Joint Replacement  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Pain | Location:  Cause:  Intensity: Scale of 1 to 10 (worst): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relieved by: |
| Psychological/Cognitive (Select all that apply) | |
| **Problem** *(Select all that apply)* | **Assessment** |
| Alert  Oriented to: Person Place  Time  Forgetful  Confused  Anxiety  Sad/Depressed ( Depression screen)  Paranoid  Cognitive Impairment (SLUMS)  Mental Illness  Behavior Issues  Wandering  Agitation  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Level Of Cooperation:  Cooperative  Unpredictable Not Cooperative  Diagnosis: |

**Evaluation / Baseline Assessment completed by:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of RN Date

**SLUMS Cognitive Assessment**

|  |  |  |  |  |  |  |  |
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| **#** | **Question** | **Client Answer** | **Correct Answer** | **Points** | | **Points Possible** | |
| 1 | What day of the week is it? |  | **Today's day** |  | | **1** | |
| 2 | What is the year? |  | **Today's year** |  | | **1** | |
| 3 | What state are we in? |  | **Minnesota** |  | | **1** | |
| 4 | Please remember these five objects. I will as you what they are later:   Apple/ Pen / Tie / House / Car | | | | | | | |
| 5 | You have $100 to spend and you go to the store and buy a dozen apples for $3 and a tricycle for $20. | | | | | | | |
| ***How much did you spend?*** |  | **23** |  | | **1** | |
| ***How much do you have left?*** |  | **77** |  | | **2** | |
| 6 | Please name as many animals as you can in one minute. |  |  |  | | 0-4 = **0** 5-9 = **1** 10-14 = **2** 15+ = **3** | |
| 7 | What are the five objects I asked you to remember? |  | **Apple**  **Pen**  **Tie**  **House**  **Car** |  | | **5** | |
| 8 |  | I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24. | | | | | | |
| ***87*** |  | **78** |  | | **0** | |
| ***648*** |  | **846** |  | | **1** | |
| ***8537*** |  | **7358** |  | | **1** | |
| 9 | This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock |  | |  | | | |
| ***Hour markers okay*** | Yes  No |  |  | | **2** | |
| ***Time correct*** | Yes  No | **10:50** |  | | **2** | |
| 10 | Please place an X in the Triangle | | | |  | | **1** | |
| 11 | Which of the above figures is largest? |  | **Square** |  | | **1** | |
| 12 | I am going to tell you a story. Please listen carefully because afterwards I am going to ask you some questions about it.  "*Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after."* | | | | | | | |
| What was the female's name? |  | **Jill** |  | | **2** | |
| When did she go back to work? |  | **When the kids were teenagers** |  | | **2** | |
| What work did she do? |  | **Stockbroker** |  | | **2** | |
| What state did she live in? |  | **Illinois** |  | | **2** | |
|  |  |  |  |  | |  | |
|  |  |  | **Score =** | **0** | | **/30** | |

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| **High School Education** | **Scoring** | **Less than High School Education** |
| 27-30 | Normal | 25-30 |
| 21-26 | Mild Neurocognitive Disorder | 20-24 |
| 1-20 | Dementia | 1-19 |

**Evaluation / Baseline Assessment completed by:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of RN Date