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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 EyeWear 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: [x]  Hypo[ ]  Hyper[ ]  DiabetesLast 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 nightAwake 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 thenmet Jack, a devastatingly handsome man. She married him and had three children. They livedin Chicago. She then stopped work and stayed at home to bring up her children. When they wereteenagers, 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