

### ICF/IID Comprehensive Nursing Assessment

To be performed by a Registered Nurse  
(Example Form)

Individual	Date of Birth	Today's Date
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**I. Review**

Review of Health Care Team	Health Care Practitioners	Date Last Seen	Comments
Primary Care			
Psychiatrist			
Neurologist			
Dentist			
Optometrist			

Natural Supports	Relationship	Area Code and Telephone No.
Guardian/Legally Authorized Representative (LAR)		

**Health History**

Axis I:

  
  

Axis II:

  
  

Axis III:

  
  

Axis IV:

  
  

History of Major Medical/Surgical Occurrences:

RN \_\_\_\_\_



Individual \_\_\_\_\_ Date \_\_\_\_\_

**II. Current Status**

**Current medical and psychiatric history**

Briefly describe recent changes in health or behavioral status, hospitalizations, falls, seizure activity, restraints, etc., within the past year.

What is of primary concern/greatest expressed needs of the individual, guardian/LAR and Interdisciplinary Team (IDT) from their own perspective?

**Vital Signs**

Blood pressure		Pulse		Respirations	
		Rate	Rhythm	Rate	Rhythm
Temperature	Pain level	Blood sugar		Weight	Height

**Labs**

Briefly review ordered labs, dates and abnormal values within the past year.

RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

**III. Review of Systems**

**Neurological**

<b>AIMS Assessment:</b> <input type="checkbox"/> Attached <input type="checkbox"/> Deferred		<b>Fall Risk Assessment:</b> <input type="checkbox"/> Attached <input type="checkbox"/> Deferred	
<b>Y</b>	<b>N</b>	<b>Y</b>	<b>N</b>
Headaches.....	<input type="checkbox"/> <input type="checkbox"/>	PERLA.....	<input type="checkbox"/> <input type="checkbox"/>
Dizziness.....	<input type="checkbox"/> <input type="checkbox"/>	Tremors.....	<input type="checkbox"/> <input type="checkbox"/>
Impaired Balance/ Coordination.....	<input type="checkbox"/> <input type="checkbox"/>	Numbness/Tingling/ Paresthesia.....	<input type="checkbox"/> <input type="checkbox"/>
Med side effects affecting...	<input type="checkbox"/> <input type="checkbox"/>	Paralysis.....	<input type="checkbox"/> <input type="checkbox"/>
	<b>Y</b>	<b>N</b>	<b>Y</b>
<b>Seizures</b> .....	<input type="checkbox"/> <input type="checkbox"/>	Petit Mal.....	<input type="checkbox"/> <input type="checkbox"/>
Frequency _____		Absence.....	<input type="checkbox"/> <input type="checkbox"/>
Duration _____		Myoclonic (sporadic jerking)..	<input type="checkbox"/> <input type="checkbox"/>
Comments		Clonic (repetitive jerking).....	<input type="checkbox"/> <input type="checkbox"/>
		Tonic (muscle rigidity).....	<input type="checkbox"/> <input type="checkbox"/>
		Atonic (loss of muscle tone)..	<input type="checkbox"/> <input type="checkbox"/>

**EENT**

Eyes/Vision	
<input type="checkbox"/> Clear <input type="checkbox"/> Red <input type="checkbox"/> Right impaired <input type="checkbox"/> Left impaired <input type="checkbox"/> Adaptive aid	
Ears/Hearing	
<input type="checkbox"/> Normal <input type="checkbox"/> Ringing <input type="checkbox"/> Right impaired <input type="checkbox"/> Left impaired <input type="checkbox"/> Adaptive aid	
Nose/Smell	
<input type="checkbox"/> WNL Smell: <input type="checkbox"/> intact <input type="checkbox"/> not intact <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Frequent sinus congestion <input type="checkbox"/> Frequent sinus infection	
Oral	
<input type="checkbox"/> WNL <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Mouth pain <input type="checkbox"/> Halitosis <input type="checkbox"/> Dentures <input type="checkbox"/> Edentulous <input type="checkbox"/> Involuntary tongue movement	
<input type="checkbox"/> Dry mouth from meds	
Throat	
<input type="checkbox"/> WNL <input type="checkbox"/> Sore throats <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Tonsil <input type="checkbox"/> History of choking enlargement	
<input type="checkbox"/> Thyroid enlargement	
Swallow Study: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Results: _____	

Comments
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RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

**Cardiovascular**

	Y	N		Y	N		Y	N
Edema.....	<input type="checkbox"/>	<input type="checkbox"/>	Cool/Numb Extremities.....	<input type="checkbox"/>	<input type="checkbox"/>	Capillary refill brisk.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Activities of daily living (ADL) limitations.....	<input type="checkbox"/>	<input type="checkbox"/>	Ted hose.....	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure...	<input type="checkbox"/>	<input type="checkbox"/>						
Normal Range _____								
Comments								

**Gastrointestinal**

<input type="checkbox"/> Gastrostomy <input type="checkbox"/> Jejunostomy <input type="checkbox"/> No tube			Last BM			Bowel Habits (frequency and description)		
	Y	N		Y	N		Y	N
Bowel Sounds			Reflux.....	<input type="checkbox"/>	<input type="checkbox"/>	History of Risk Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Continent.....	<input type="checkbox"/>	<input type="checkbox"/>	Straining pain.....	<input type="checkbox"/>	<input type="checkbox"/>	History of Risk Impaction.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nausea.....	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Program.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent vomiting.....	<input type="checkbox"/>	<input type="checkbox"/>	Odd stools.....	<input type="checkbox"/>	<input type="checkbox"/>	Meds influencing bowels (laxatives, anti-diarrheals, Iron, Ca, Anticholinergics, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids.....	<input type="checkbox"/>	<input type="checkbox"/>			
Heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	Independent toileting.....	<input type="checkbox"/>	<input type="checkbox"/>			
Appetite loss.....	<input type="checkbox"/>	<input type="checkbox"/>						
Comments								

**Respiratory**

<b>Breathing:</b> <input type="checkbox"/> Slow <input type="checkbox"/> Normal <input type="checkbox"/> Rapid <input type="checkbox"/> Shallow <input type="checkbox"/> Painful								
	Y	N		Y	N		Y	N
SOB.....	<input type="checkbox"/>	<input type="checkbox"/>	Feeding tube.....	<input type="checkbox"/>	<input type="checkbox"/>	Trach.....	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing.....	<input type="checkbox"/>	<input type="checkbox"/>	Positioning orders.....	<input type="checkbox"/>	<input type="checkbox"/>	CPAP.....	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspiration history.....	<input type="checkbox"/>	<input type="checkbox"/>	Inhalation agent.....	<input type="checkbox"/>	<input type="checkbox"/>
Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia history.....	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen @	<input type="checkbox"/>	<input type="checkbox"/>
Productive.....	<input type="checkbox"/>	<input type="checkbox"/>						
Comments								

RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

**Musculoskeletal**

**Fall Risk Assessment:**  Attached  Deferred

	Y	N		Y	N		Y	N
Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis.....	<input type="checkbox"/>	<input type="checkbox"/>	Impaired ROM.....	<input type="checkbox"/>	<input type="checkbox"/>
Weakness.....	<input type="checkbox"/>	<input type="checkbox"/>	Deformity.....	<input type="checkbox"/>	<input type="checkbox"/>	Impaired gait.....	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness.....	<input type="checkbox"/>	<input type="checkbox"/>	Contractures.....	<input type="checkbox"/>	<input type="checkbox"/>	Adaptive equipment.....	<input type="checkbox"/>	<input type="checkbox"/>

Comments

**Genitourinary**

	Y	N		Y	N		Y	N
Continent.....	<input type="checkbox"/>	<input type="checkbox"/>	Flank pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually active.....	<input type="checkbox"/>	<input type="checkbox"/>
Stress.....	<input type="checkbox"/>	<input type="checkbox"/>	History of UTIs.....	<input type="checkbox"/>	<input type="checkbox"/>	Prostate issues.....	<input type="checkbox"/>	<input type="checkbox"/>
Urge.....	<input type="checkbox"/>	<input type="checkbox"/>	Nocturia.....	<input type="checkbox"/>	<input type="checkbox"/>	Cycle regular.....	<input type="checkbox"/>	<input type="checkbox"/>
Bladder program.....	<input type="checkbox"/>	<input type="checkbox"/>	Discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	Date LMP: _____		
Frequent urination.....	<input type="checkbox"/>	<input type="checkbox"/>	Itching.....	<input type="checkbox"/>	<input type="checkbox"/>			
Cloudy/dark urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemodialysis.....	<input type="checkbox"/>	<input type="checkbox"/>			
Bloody urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Peritoneal dialysis.....	<input type="checkbox"/>	<input type="checkbox"/>			

Comments

**Integumentary**

**Braden Skin Assessment:**  Attached  Deferred

**Skin:**  Normal  Moist  Dry  Cyanotic  Warm  Pale  Jaundice  Cold  Dusky  Flushed

	Y	N		Y	N		Y	N
Open wound.....	<input type="checkbox"/>	<input type="checkbox"/>	Rash.....	<input type="checkbox"/>	<input type="checkbox"/>	Blemished.....	<input type="checkbox"/>	<input type="checkbox"/>
Bruising.....	<input type="checkbox"/>	<input type="checkbox"/>	Diaphoretic.....	<input type="checkbox"/>	<input type="checkbox"/>	Poor skin turgor.....	<input type="checkbox"/>	<input type="checkbox"/>
Breakdown related to adaptive aids/prosthesis....	<input type="checkbox"/>	<input type="checkbox"/>	Risk for breakdown.....	<input type="checkbox"/>	<input type="checkbox"/>	History of breakdown....	<input type="checkbox"/>	<input type="checkbox"/>
Risk of breakdown.....	<input type="checkbox"/>	<input type="checkbox"/>						

Comments

RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

**Endocrine**

	<b>Y</b>	<b>N</b>		<b>Y</b>	<b>N</b>	
Thyroid dysfunction.....	<input type="checkbox"/>	<input type="checkbox"/>	<b>Diabetes</b> .....	<input type="checkbox"/>	<input type="checkbox"/>	Type _____
Atypicals or other meds affecting blood sugar.....	<input type="checkbox"/>	<input type="checkbox"/>	Management: <input type="checkbox"/> Diet	<input type="checkbox"/> Oral meds	<input type="checkbox"/> Insulin	
Pre-Diabetic Hypoglycemic/ Hyperglycemic episodes....	<input type="checkbox"/>	<input type="checkbox"/>	Typical Ranges:			
Comments						

**IV. Additional Health Status Information**

**Immunizations: Date last received**

DPT	TOPV	HIB	MMR	TD	TDS	Flu Shot

**Nutritional Assessment**

How Receive Nutrition:  Orally  Via gastronomy tube if residual < \_\_\_\_\_  Via jejunostomy tube

Therapeutic Diet \_\_\_\_\_ Liquid consistency \_\_\_\_\_

Food Texture \_\_\_\_\_ Reason/Date/Ordered by: \_\_\_\_\_

	<b>Y</b>	<b>N</b>	
Recent weight change.....	<input type="checkbox"/>	<input type="checkbox"/>	_____ lbs. <input type="checkbox"/> gain <input type="checkbox"/> loss over _____
Recent changes in appetite/medication.....	<input type="checkbox"/>	<input type="checkbox"/>	
Satisfied with current weight.....	<input type="checkbox"/>	<input type="checkbox"/>	Desired weight range _____
Food use as a coping mechanism.....	<input type="checkbox"/>	<input type="checkbox"/>	
Assistive devices with eating.....	<input type="checkbox"/>	<input type="checkbox"/>	
Use of meds that can cause difficulty swallowing (e.g., Abilify, other psychoactives)	<input type="checkbox"/>	<input type="checkbox"/>	
Knowledge of 4 basic food groups.....	<input type="checkbox"/>	<input type="checkbox"/>	
Access to healthy/appropriate diet.....	<input type="checkbox"/>	<input type="checkbox"/>	
Dietary deficiencies.....	<input type="checkbox"/>	<input type="checkbox"/>	
Adequate fluid intake.....	<input type="checkbox"/>	<input type="checkbox"/>	
Nutritional supplements.....	<input type="checkbox"/>	<input type="checkbox"/>	
Interactions with meds and food.....	<input type="checkbox"/>	<input type="checkbox"/>	

RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

**Sleep Patterns**

Average no. of hours per night; difficulty falling asleep; no. of times awake at night; no. of naps during a day

**Activity Level/Exercise**

**Substance Use/Abuse**

Caffeine, tobacco, alcohol, recreational drugs, history of non-compliance with prescribed meds

**Home Life**

Satisfaction/Desires

**Work/School/Day Activity**

Satisfaction/Desires

**Social Life**

Satisfaction/Desires

**Spiritual Life**

Satisfaction/Desires

**Coping Skills**

RN \_\_\_\_\_



Individual \_\_\_\_\_ Date \_\_\_\_\_

**Mental Status**

**Appearance**

**Posture:**  Normal  Rigid  Slouched  Other:

**Grooming and Dress:**  Appropriate  Inappropriate  Disheveled  Neat

**Facial Expression:**  Calm  Alert  Stressed  Perplexed  Tense  Dazed  Other:

**Eye contact:**  Eyes not open  Good contact  Avoids contact  Stares

**Speech Quality:**  Clear  Slow  Slurred  Loud  Rapid  Incoherent  Mute

**Mood**

- |   |  |                                    |                                     |
|---|--|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Cooperative    | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Depressed | <input type="checkbox"/> Euphoric   |
| <input type="checkbox"/> Excited        | <input type="checkbox"/> Agitated      | <input type="checkbox"/> Anxious   | <input type="checkbox"/> Suspicious |
| <input type="checkbox"/> Irritable      | <input type="checkbox"/> Scared        | <input type="checkbox"/> Hostile   | <input type="checkbox"/> Angry      |
| <input type="checkbox"/> Other/Describe |  |                                    |                                     |

**Cognition**

	Y	N		Y	N		Y	N
<b>Cognitive impairment</b>			<b>Oriented</b>			<b>Attention span</b>		
Mild.....	<input type="checkbox"/>	<input type="checkbox"/>	Person.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily distracted.....	<input type="checkbox"/>	<input type="checkbox"/>
Moderate.....	<input type="checkbox"/>	<input type="checkbox"/>	Place.....	<input type="checkbox"/>	<input type="checkbox"/>	Impaired judgment.....	<input type="checkbox"/>	<input type="checkbox"/>
Severe.....	<input type="checkbox"/>	<input type="checkbox"/>	Time.....	<input type="checkbox"/>	<input type="checkbox"/>			
Profound.....	<input type="checkbox"/>	<input type="checkbox"/>						

**Memory**

- |                       |                          |                          |
|-----------------------|--------------------------|--------------------------|
| Remote.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent.....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Immediate Recall..... | <input type="checkbox"/> | <input type="checkbox"/> |

**Emotions**

	Y	N		Y	N		Y	N
Euphoric.....	<input type="checkbox"/>	<input type="checkbox"/>	Depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	Hostile feelings.....	<input type="checkbox"/>	<input type="checkbox"/>
Happy.....	<input type="checkbox"/>	<input type="checkbox"/>	Anxious.....	<input type="checkbox"/>	<input type="checkbox"/>	Labiality of emotions.....	<input type="checkbox"/>	<input type="checkbox"/>
Apathetic.....	<input type="checkbox"/>	<input type="checkbox"/>	Irritable.....	<input type="checkbox"/>	<input type="checkbox"/>	Inappropriate affect.....	<input type="checkbox"/>	<input type="checkbox"/>
Sadness.....	<input type="checkbox"/>	<input type="checkbox"/>						

**Thoughts**

	Y	Denies		Y	Denies		Y	Denies		Y	Denies
Delusions.....	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations.....	<input type="checkbox"/>	<input type="checkbox"/>	Process.....	<input type="checkbox"/>	<input type="checkbox"/>	Content.....	<input type="checkbox"/>	<input type="checkbox"/>
Grandeur.....	<input type="checkbox"/>	<input type="checkbox"/>	Visual.....	<input type="checkbox"/>	<input type="checkbox"/>	Coherent organized.....	<input type="checkbox"/>	<input type="checkbox"/>	Phobias.....	<input type="checkbox"/>	<input type="checkbox"/>
Persecutory.....	<input type="checkbox"/>	<input type="checkbox"/>	Auditory.....	<input type="checkbox"/>	<input type="checkbox"/>	Logical.....	<input type="checkbox"/>	<input type="checkbox"/>	Hypochondria.....	<input type="checkbox"/>	<input type="checkbox"/>
Somatic.....	<input type="checkbox"/>	<input type="checkbox"/>	Tactile.....	<input type="checkbox"/>	<input type="checkbox"/>				Antisocial urges.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	Olfactory.....	<input type="checkbox"/>	<input type="checkbox"/>				Obsessions.....	<input type="checkbox"/>	<input type="checkbox"/>
									Suicidal ideations.....	<input type="checkbox"/>	<input type="checkbox"/>

RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

**Behaviors**

Are medications used to control any behaviors? <input type="checkbox"/> Y <input type="checkbox"/> N		Currently on formal Behavior Plan? <input type="checkbox"/> Y <input type="checkbox"/> N	
	<b>Y</b> <b>N</b>		<b>Y</b> <b>N</b>
Hurtful to self.....	<input type="checkbox"/> <input type="checkbox"/>	Uncooperative (describe).....	<input type="checkbox"/> <input type="checkbox"/>
PICA.....	<input type="checkbox"/> <input type="checkbox"/>	Disruptive (describe).....	<input type="checkbox"/> <input type="checkbox"/>
History of suicide attempt...	<input type="checkbox"/> <input type="checkbox"/>		
		Hurtful to others.....	<input type="checkbox"/> <input type="checkbox"/>
		Destructive to property.....	<input type="checkbox"/> <input type="checkbox"/>

Behaviors: Description, frequency, severity and outcomes. What are effective prevention or redirection strategies?

**Communication**

Primary language:

Mark ways that pain is communicated.

	<b>Y</b> <b>N</b>		<b>Y</b> <b>N</b>		<b>Y</b> <b>N</b>
Verbal	<input type="checkbox"/> <input type="checkbox"/>	Facial expressions	<input type="checkbox"/> <input type="checkbox"/>	Touch	<input type="checkbox"/> <input type="checkbox"/>
Limited verbal	<input type="checkbox"/> <input type="checkbox"/>	Eye movement	<input type="checkbox"/> <input type="checkbox"/>	Body language	<input type="checkbox"/> <input type="checkbox"/>
Non-verbal	<input type="checkbox"/> <input type="checkbox"/>	Paralinguistics (sounds)	<input type="checkbox"/> <input type="checkbox"/>	Acting out	<input type="checkbox"/> <input type="checkbox"/>
Gestures	<input type="checkbox"/> <input type="checkbox"/>			Head banging	<input type="checkbox"/> <input type="checkbox"/>
				Other behaviors (describe)	<input type="checkbox"/> <input type="checkbox"/>
Able to use pain scale	<input type="checkbox"/> <input type="checkbox"/>	Faces pain scale	<input type="checkbox"/> <input type="checkbox"/>	Numeric Scale	<input type="checkbox"/> <input type="checkbox"/>
				1 (least) – 10 (greatest)	

Comments

Individual \_\_\_\_\_ Date \_\_\_\_\_

**V. Implementation Assessment**

**Health care and Decision Making Capacity**

The preceding review of functional capabilities, physical and cognitive status, and limitations indicate this individual's highest level of ability to make health care decisions.

- Probably can make higher level decisions (such as whether to undergo or withdraw life sustaining treatments that require understanding the nature, probable consequences, burdens and risks of proposed treatment).
- Probably can make limited decisions that require simple understanding, able to direct own health care, including delegated tasks.
- Probably can express agreement with decisions proposed by someone else.
- Cannot effectively participate in any kind of health care decision making.

**Stability and Predictability and Need to Reassess**

Health Topic	Is a long-term need non-fluctuating consistent?		Status change possible, or likely to need regular nursing care		Frequency of RN reassessment
	Y	N	Y	N	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Knowledge: Describe key health understandings/demonstrations.**

Health Topic	Description	Individual			IDT		
		Y	N	N/A	Y	N	N/A
	Knowledgeable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Demonstrates Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Knowledgeable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Demonstrates Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Knowledgeable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Demonstrates Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Knowledgeable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Demonstrates Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

Health Topic	Description	Individual			IDT		
		Y	N	N/A	Y	N	N/A
	Knowledgeable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Demonstrates Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments

RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

**Individual in Comprehensive Assessment**

**Individual**

I have participated in decisions about the overall management of my health care. [§225.1(2)]

I can make all of my own decisions, and am able to direct own health care.

**or**

I have a guardian, LAR or IDT member act as my client responsible adult (CRA).

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CRA**     **IDT to serve as CRA**

I have participated in decisions about the overall management of health care. [§225.1(2)]

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Registered Nurse (RN)**

I have developed this plan and retain accountability for delegated tasks. Each assistive personnel's competency will be verified before allowing delegated tasks to be performed without direct nursing supervision. An RN will be immediately accessible by phone to the assistive personnel when the task is performed.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

RN \_\_\_\_\_



Individual \_\_\_\_\_ Date \_\_\_\_\_

### Safe Administration of Medications

Based on a comprehensive review of functional capabilities, physical and cognitive status, limitations and natural supports rate this individual's ability to take his/her own medications in a safe and appropriate manner according to the 5 Rights of Medication Administration (correct person, medication [what, why], dose, time, route). **RN Delegation Worksheet**  Attached  Deferred

**Self-Administration of Medication.** Individual knows how to safely take each medication (what, why) dose, route, time of each medication. The individual is competent to safely self-administer medications independently or independently with ancillary aid provided to the individual in the individual's self-administered medication treatment or regimen, such as reminding an individual to take a medication at the prescribed time, opening and closing a medication container, pouring a predetermined quantity of liquid to be ingested, returning a medication to the proper storing area, and assisting in reordering medications from a pharmacy. **No RN Delegation is necessary.** [§225.1(3)]

**Administration of medication** to an individual by a paid unlicensed person(s) to ensure that medications are received safely. Administration of medications includes removal of an individual/unit dose from a previously dispensed, properly labeled container; verifying it with the medication order; giving the correct medication and the correct dose to the proper individual at the proper time by the proper route; and accurately recording the time and dose given. [TX BON §225.4(2)]

**RN delegation necessary to ensure safe medication administration.**

RN can safely authorize unlicensed personnel to administer medications for stable and predictable conditions as defined in §225.4(11) not requiring nursing judgment. Competency of each assistive personnel, including the ability to recognize and inform the RN of individual changes related to the task must be verified by RN. The six rights of delegation (the right task, the right person to whom the delegation is made, the right circumstances, the right direction and communication by the RN, the right supervision, and the right documentation) and all criteria at §225.9 must be met. Individual (if competent), guardian/LAR and/or IDT must approve the decision of the RN to delegate tasks in writing. See Delegation Criteria at §225.9, §225.10.

#### Routes That May Be Delegated

**The RN has determined that delegation is not required for oral, topical and metered dose inhalers.** The RN has determined that the medications not being delegated to paid unlicensed staff are for a stable or predictable condition. The RN or LVN, under the direction of an RN, has trained and determined the paid unlicensed staff(s) competency. [Human Resources Code, Chapter 161, Subchapter D]

**Must be administered by a licensed nurse.** Medications that **may not be delegated** are:

RN \_\_\_\_\_

Individual \_\_\_\_\_ Date \_\_\_\_\_

**VI. Summary**

**Summary/Clinical Impressions**

Strengths as related to health
Consultations recommended
Summary

**Nursing Service Plan**

Concerns/Nursing Diagnoses
Intervention/Strategies
Desired Outcomes/Goals

\_\_\_\_\_  
Print Name and Credentials

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

RN \_\_\_\_\_