

*Hospital Back Up Onsite Nursing Assessment*

**Dual Diagnosis Management**

227 French Landing Drive; Suite 250; Nashville, Tennessee 37228  
Phone: (877) 431-1388 Fax: (877) 431-9568

**General  
Information**

Evaluation Type:  2 Week Post Admission  CSR

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Admit Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Legal Representative Information:  No legal Representative

Legal Representative: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Race/Ethnic Origin:  African American  Asian  Caucasian  Hispanic  Other \_\_\_\_\_

Gender:  Female  Male

Admitting Information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Source(s) of Information:  Client  Family Member (document relationship): \_\_\_\_\_

Chart Review: Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

Medical History, Illnesses, Hospitalizations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Source(s) of information:  Client  Family Member (document relationship): \_\_\_\_\_

Chart Review: Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_



Dietary: Height \_\_\_\_\_ Weight \_\_\_\_\_

Diet:  N/A \_\_\_\_\_ Supplements:  N/A \_\_\_\_\_

Comments:  
\_\_\_\_\_  
\_\_\_\_\_

Source(s) of Information:  Client  Family Member (document relationship): \_\_\_\_\_

Chart Review: Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

Attending Orders and Progress Notes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Source(s) of Information:  Client  Family Member (document relationship): \_\_\_\_\_

Chart Review: Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

Nursing Notes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Source(s) of Information:  Client  Family Member (document relationship): \_\_\_\_\_

Chart Review: Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

Consults:  N/A \_\_\_\_\_

Labs:  N/A \_\_\_\_\_

X-rays:  N/A \_\_\_\_\_

Source(s) of Information:  Client  Family Member (document relationship): \_\_\_\_\_

Chart Review: Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

ADLs &  
Assessments  
**4**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

**TRANSFERRING:**

- Independent    Safely without assistance    Requires standby or hands on assistance  
 Total assistance for transfers/positioning

Comments:

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**EATING:**

- Independent       Can feed self, chew, and swallow foods  
 Feeds self but needs standby assistance due to frequent gagging, choking, swallowing, or aspiration or need of medical intervention  
 Must be totally fed by another person, stomach tube, venous access

Comments:

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Source(s) of Information:  Client     Family Member (document relationship): \_\_\_\_\_

Chart Review:    Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

**SUPERVISION:**    Appropriate behavior    Some inappropriate behavior/no injury to self

- Inappropriate behavior that puts self/others at risk    Requires extensive supervision to prevent harm to self or others

Comments:

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**MEMORY:**    Independent    Makes safe decisions in familiar situations    Requires consistent and ongoing reminding

- Requires help most or all of the time, medication must be administered to client

Comments:

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**BATHING:**    Independent    Oversight help or reminding    Requires hands on/standby assistance    Dependent on others

Comments:

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**DRESSING:**    Independent    Dress & undress with or without assistive devices    Significant verbal or physical assistance to complete  
 Totally dependent

Comments:

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**TOILETING:**    Independent    Minimal assistance    Physical/standby assistance    Unable to use toilet/dependent or continuous observation

Comments:

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**MOBILITY:**    Independent    Mobile in own home, needs assistance outside of home

- Not safe to ambulate between locations alone    Totally dependent

Comments:

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Source(s) of Information:  Client     Family Member (document relationship): \_\_\_\_\_

Chart Review:    Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

**A. Ventilator-Dependent (must meet the following criteria)** **\*Must meet either A, B or C AND D\***

- ⚙ **Level I – (Lowest level)** Requires continuous ventilator support between 8 and 24 hours each day along with **at least 3 of the following:** 1) needs skilled nursing or respiratory therapy at least 3.5 hours each day in order to remain medically stable; 2) requires access to respiratory therapy staff and modality support; 3) has an ADL score of at least 10 on the MDS assessment form; and 4) has difficulty communicating needs, as evidenced by a score of at least 1 on the speech clarity section of the MDS assessment form.
- ⚙ **Level II - (moderate level)** Requires continuous ventilator support between 8 and 24 hours each day along with **at least 3 of the following:** 1) needs skilled nursing or respiratory therapy at least 6.5 hours each day in order to remain medically stable; 2) requires access to respiratory therapy staff and modality support; 3) has an ADL score of at least 10 on the MDS assessment form; and 4) is unable to communicate needs.
- ⚙ **Level III – (highest level)** Applies to a client who is actively weaning from the ventilator; requires intermittent ventilator support between 2 and 24 hours each day; needs skilled nursing or respiratory therapy at least 12 hours each day in order to progress with weaning; requires physical therapy, occupational therapy and/or speech therapy five days per week and; has documented rehabilitation potential.

Source(s) of Information:  Client  Family Member (document relationship): \_\_\_\_\_

Chart Review: Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

**Respiratory Therapy:** \_\_\_\_\_

**Trach:** \_\_\_\_\_

**Vent:** \_\_\_\_\_

**Suctioning:** \_\_\_\_\_

**Secretions:** \_\_\_\_\_

**Lung Sounds:** \_\_\_\_\_

**B. Wound Care (must meet the following criteria)**

- ⚙ **One of the following:** 1) Complex surgical or traumatic wound; 2) Complicated wound graft surgery; 3) At least one stage III or stage IV pressure ulcer requiring a Medicare-rated group 2 or 3 pressure-relieving surface or 4) a specialized wound-healing device (i.e., Wound-Vac).
- ⚙ Existing *nutritional deficiencies* are being treated.
- ⚙ *Debridement therapy* has been initiated, if indicated.
- ⚙ *SURC & Departmental staff have individually evaluated* whether applicant is appropriate.
- ⚙ Applicant has had a *consultation with a wound specialist, and a resulting treatment plan* has been initiated.

**Note: The Skin/Wound assessment must be completed**

Source(s) of Information:  Client  Family Member (document relationship): \_\_\_\_\_

Chart Review: Area of Chart: \_\_\_\_\_ Information Date: \_\_\_\_\_ Other: \_\_\_\_\_

