Patient Assessment Form

Patient Information

Patient Name:	John Doe	**DOB:**	02/22/1954
Gender:	Female	**Clinician Name:**	Jane Doe
Address:	101 Bedford Avenue, Brooklyn, NY		
Phone #:	212-718-9005	**Alt. Phone #:**	212-718-9006
Primary Language:	English	**Language Barrier:**	☐ Yes ☑ No
Living Arrangement:	☑ Lives Alone ☐ With Spouse ☐ Lives with family ☐ Lives with Friend/Significant Other:		

Visit Information

Date of Visit:	02/09/2026	**Time In:**	02/09/2026 16:51	**Time Out:**	02/09/2026 17:51
Type of Assessment:	☐ Initial ☑ Reassessment				
Priority Code:	☐ Level 1 (High - requires immediate attention) ☑ Level 2 (Moderate - needs scheduled care) ☐ Level 3 (Low - stable, preventive care)				
TAL Status:	☐ TAL-1 Non-ambulatory stretcher ☐ TAL-1 Non-ambulatory vent ☐ TAL-1 Non-ambulatory bariatric ☑ TAL-2 Wheelchair ☐ TAL-3 Ambulatory				
RN Narrative/Notes:	Lives alone; ambulates with rollator with noted unsteadiness; receiving chemotherapy every three weeks for bilateral metastatic breast cancer; currently not on any medications.				

Vital Signs

Temperature:	97.9 °F ☐ Oral ☐ Axillary ☑ Temporal ☐ Rectal
Blood Pressure:	128/78 mmHg ☐ Right Arm ☑ Left Arm
Pulse:	92 beats per minute ☑ Regular ☐ Irregular
Respirations:	18 breaths per minute ☑ Regular ☐ Irregular ☐ Shallow ☐ Labored
Blood Glucose:	N/A mg/dL (if applicable)
RN Narrative/Notes:	All vitals within normal limits.

Fall Risk Assessment

Fall Risk Factors:	☑ Age 65+ ☐ History of falls in past 3 months ☑ 3+ medical diagnoses ☐ Taking 4+ medications ☑ Impaired balance/gait ☑ Visual impairment ☐ Cognitive impairment ☐ Urinary frequency/incontinence ☐ Use of assistive device ☑ Environmental hazards present
Total Score:	5 **Risk Level:** ☐ Low (0-3) ☑ Moderate (4-6) ☐ High (7+)
RN Narrative/Notes:	Denies falls in past 3 months.

Neurological Assessment

Mental Status:	☑ Oriented ☐ Comatose ☐ Forgetful ☑ Depressed ☐ Disoriented ☐ Agitated ☐ Lethargic ☑ Alert
Additional Neurological:	☐ WNL ☐ Seizures ☐ Tremors ☐ Paralysis ☐ Headache ☑ Ataxia ☐ Dizziness
Psychological:	☐ WNL ☑ Depression ☐ Anxiety ☐ Fear ☐ Suicidal Thoughts ☐ Hallucinations ☐ Delusions ☐ Poor Insight/Judgment ☐ Memory Loss ☐ History of previous psych illness
Teaching Provided:	I encouraged engagement in social activities, instructed on medication compliance for mood symptoms, and taught fall-prevention strategies and safe use of assistive devices for ataxia.
RN Narrative/Notes:	Alert and oriented x3. Reports ongoing depression related to past losses.

EENT (Eyes, Ears, Nose, Throat)

Head/Face:	☑ WNL ☐ Drainage ☐ Alopecia ☐ Epistaxis ☐ Congestion ☐ Facial Twitching ☐ Sinus Abnormality
Eyes/Vision:	☐ WNL ☑ Visual Impairment ☐ Legally Blind ☑ Glasses ☐ Contact Lenses ☐ Glaucoma ☐ Cataracts ☐ Discharge
Ears/Hearing:	☐ WNL ☑ Hearing Loss ☐ Hearing Aid ☐ Deaf ☐ Tinnitus ☐ Discharge
Mouth/Throat/Speech:	☐ WNL ☐ Bleeding Gums ☐ Dysphagia ☐ Gingivitis ☐ Speech Impairment ☐ Dentures ☑ Missing Teeth ☐ Hoarseness ☐ Sore Throat ☐ Ageusia ☐ Anosmia
Teaching Provided:	I instructed on home safety for visual impairment and importance of wearing glasses as prescribed. I taught communication strategies for partial hearing loss. I educated on safe chewing techniques and oral hygiene related to missing teeth.
RN Narrative/Notes:	Wears glasses; missing teeth; bilateral hard of hearing; no hearing aids.

Cardiopulmonary Assessment

Cardiovascular:	☑ WNL ☐ Chest Pain ☐ Palpitations ☐ Pacemaker ☐ Fatigues Easily ☐ Edema ☐ Murmur ☐ Clubbing ☐ Cyanosis ☐ Syncope ☐ Activity Intolerance
Respiratory:	☑ WNL ☐ SOB at rest ☐ Orthopnea ☐ PND ☐ Cough ☐ Sputum ☐ Tracheostomy ☐ Ventilator ☐ BIPAP ☐ CPAP
Lung Sounds:	☐ Clear ☐ Rales ☐ Wheezing ☐ Rhonchi ☑ Diminished ☐ Absent
Teaching Provided:	No cardiopulmonary symptoms reported; lung sounds diminished. I instructed on importance of mobility, deep breathing, and use of incentive spirometer if prescribed, and to report any new shortness of breath or changes.
RN Narrative/Notes:	Denies cardiovascular or pulmonary issues.

Musculoskeletal Assessment

Assessment:	☐ WNL ☑ Weakness ☑ Gait Abnormality ☐ Amputation ☐ Numbness ☐ Stiffness ☐ Deformities ☑ Coordination Problems ☑ Limited ROM
Teaching Provided:	I instructed on proper use of assistive devices and safety measures for ambulation. I taught importance of following prescribed therapy, proper positioning, and gradual movement progression. I educated on adaptive techniques to improve coordination and conserve energy during daily activities.
RN Narrative/Notes:	Ambulates with rollator; gait very unsteady. Requires support from furniture when opening or closing doors. High fall risk.

Pain Assessment

Pain Status:	☑ Not Present ☐ Present **Pain Intensity (0-10):** N/A
Characteristics:	☐ Burning ☐ Aching ☐ Throbbing ☐ Sharp ☐ Crushing ☐ Radiating
Location & Duration:	**Location:** N/A **Duration:** N/A
Pain Management:	Relief Methods (Medication, Ice, Elevation, other): **Effective:** ☐ Yes ☐ No
Non-Verbal Pain Assessment:	☑ None Reported/Observed ☐ Facial Grimaces ☐ Restlessness ☐ Guarding ☐ Rigidity ☐ Moaning ☐ Crying
Teaching Provided:	N/A
RN Narrative/Notes:	Denies pain.

GI/GU/Reproductive Assessment

Gastrointestinal:	☑ WNL ☐ Hernia ☐ Nausea/Vomiting ☐ Ulcers ☐ Incontinence ☐ Rectal Bleeding ☐ Hemorrhoids ☐ Diarrhea ☐ Indigestion ☐ Tenderness ☐ Pain ☐ Constipation ☐ Ostomy: N/A
Genitourinary:	☑ WNL ☐ Incontinence ☐ Frequency ☐ Urgency ☐ Burning ☐ Hesitancy ☐ Oliguria ☐ Dysuria ☐ Polyuria ☐ Anuria ☐ Hematuria ☐ Nocturia ☐ Dialysis ☐ Retention ☐ Urinary Catheter: N/A
Reproductive:	**FEMALE:** ☐ No Problems ☐ Hysterectomy ☑ Mastectomy ☐ Discharge/Bleeding ☐ Breast Abnormalities ☑ Other: 2019
Teaching Provided:	I instructed on proper long-term post-mastectomy skin care, taught the importance of monitoring for swelling or changes, and educated on performing arm exercises as recommended and when to seek medical attention for new symptoms.
RN Narrative/Notes:	Denies GI and GU issues. History of bilateral mastectomy in 2019 for metastatic breast cancer.

Nutritional Assessment

Appetite:	☐ Good ☐ Fair ☑ Poor ☐ Excessive
Weight & Fluids:	**Weight:** 111 lbs ☐ Stable ☑ Loss ☐ Gain **Fluid Restriction:** ☑ No ☐ Yes
Food Intake:	☑ Independent ☐ Needs Assistance ☐ Dependent ☐ Tube Feeding ☐ NPO
Nutritional Requirements:	☐ Regular/No Restrictions ☐ Cardiac ☐ Pureed ☐ Low Sodium ☐ Low Fat ☐ Low Cholesterol ☐ Low Sugar ☐ No Concentrated Sweets ☐ High Fiber ☑ Soft ☐ Renal ☐ 1800 Cal ADA
Teaching Provided:	I instructed on small frequent meals and high-calorie foods, taught importance of taking nutritional supplements, educated on monitoring weight, and instructed on soft diet preparation and safe swallowing techniques.
RN Narrative/Notes:	Denies allergies; mild weight loss from chemotherapy; no diet restrictions.

Allergies

Allergies:	Medication Allergies: NKDA. Food Allergies: NKA. Substance/Environmental Allergies: NKA

Integumentary / Hematopoietic / Endocrine

Integumentary:	☑ WNL ☐ Dry ☐ Rash ☐ Pallor ☐ Fistula ☐ Wound ☐ Pressure areas ☐ Incisions ☐ Poor Turgor ☐ Scars ☐ Bruises ☐ Pruritus ☐ Lesions
Hematopoietic:	☑ WNL ☐ Anemia ☐ Excessive Bleeding or Bruising ☐ Intolerance to Heat & Cold ☐ Clotting Disorder
Endocrine:	☑ No Problems ☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism
Skin Properties:	**Color:** ☑ WNL ☐ Pale ☐ Cyanotic ☐ Jaundice **Edema:** N/A
Wound Assessment:	N/A
RN Narrative/Notes:	Denies diabetes mellitus or thyroid issues.

Medication Profile

Medication Name	Dosage	Frequency	Notes
Levothyroxine (Oral Pill)	0.125 mg Tab	Once daily	Route confirmed as oral
Atorvastatin (Oral Pill)	40 mg Tab	Once daily	Route confirmed as oral
Losartan (Oral Pill)	100 mg Tab	Once daily	Route confirmed as oral
Memantine (Oral Pill)	10 mg Tab	5 mg orally twice daily for 1 week, then increase to 10 mg orally twice daily	Route confirmed as oral
metFORMIN (Oral Pill)	500 mg Tab	Once daily	Route confirmed as oral
NIFEdipine XR (Oral Pill)	60 mg 24 HR XR Tab	Once daily	Route confirmed as oral
JARDIANCE (Oral Pill)	10 mg	Once daily	Route confirmed as oral
Omeprazole (Oral Capsule)	20 mg Cap	Once daily before breakfast	Route confirmed as oral
Aspirin (Oral Pill)	81 mg Tab	Once daily	Route confirmed as oral
RN Narrative/Notes:	Patient takes all medications as prescribed. Medication compliance is good. No adverse effects reported.		

Diagnosis Information

Type	Diagnosis	ICD Code
Surgical	Acquired absence of unspecified breast and nipple	Z90.10
Primary	Muscle weakness (generalized)	M62.81
Other Pertinent	Unspecified lack of coordination	R27.9
Other Pertinent	Unsteadiness on feet	R26.81
Other Pertinent	Presence of spectacles and contact lenses	Z97.3
Other Pertinent	Unspecified disorder of refraction	H52.7
Other Pertinent	Unspecified hearing loss, unspecified ear	H91.90
Other Pertinent	Partial loss of teeth, unspecified cause, unspecified class	K08.409
Other Pertinent	Ataxia, unspecified	R27.0
Other Pertinent	Depression, unspecified	F32.A
Other Pertinent	Malignant neoplasm of breast	C50
Other Pertinent	Fracture of lumbar spine and pelvis	S32

DME and Supplies

DME and Supplies:

- [ ] None
- [ ] Cane
- [ ] Quad Cane
- [ ] Walker
- [ ] Wheelchair
- [x] Other: Rollator
- [ ] Hospital Bed
- [ ] Adjustable Bed
- [ ] Bed Rails
- [ ] Bedside Commode
- [ ] Trapeze Bar
- [ ] Sleeps In Recliner
- [x] Shower Chair
- [x] Grab Bars
- [x] Shower Rails
- [ ] Hand Rails
- [ ] Hoyer Lift
- [ ] Oxygen
- [ ] BiPAP
- [ ] CPAP
- [ ] Tracheostomy
- [ ] Ventilator
- [ ] Glucometer / Strips
- [ ] Wound Care Supplies
- [ ] Incontinence Supplies

Teaching Provided: I instructed on rollator safety and checking brakes. I taught safe use of shower chair, grab bars, and shower rails with attention to stability. I reviewed bathroom safety and when to seek equipment adjustment or maintenance.

RN Narrative/Notes: Patient uses a rollator, shower chair, and grab bars.

Functional Limitations

Functional Limitations:

- [ ] None
- [ ] Amputation
- [ ] Bowel/Bladder (Incontinence)
- [ ] Contracture
- [x] Hearing
- [ ] Paralysis
- [ ] Endurance
- [x] Ambulation
- [ ] Speech
- [ ] Legally Blind
- [ ] Dyspnea With Minimal Exertion

Environment / Safety Assessment

Environment/Safety Assessment:	☐ None ☑ Inadequate heating/cooling ☐ Inadequate electricity ☐ Non-functioning smoke detectors ☐ Telephone not accessible ☐ Stairs without handrails ☐ Throw rugs unsecured ☐ No emergency exit plan ☐ House/Apartment structure inadequate ☐ Inadequate plumbing/water ☐ Inadequate lighting ☐ No carbon monoxide detector ☐ No bathroom grab bars ☐ Obstructed pathways ☐ Electrical cords unsafely placed ☐ Medications not safely stored
Teaching Provided:	I instructed on proper temperature regulation and safe use of heating devices. I taught monitoring for temperature-related health risks and signs of overheating or chills. I educated on maintaining a comfortable environment and adjusting heating methods as needed for safety.
RN Narrative/Notes:	Patient uses a space heater set to 70°F but continues to feel cold related to chemotherapy.

Emergency Contacts

Contact Type	Name	Address	Phone
Local Emergency Contact	John Smith - Friend	101 Bedford Avenue, Brooklyn, NY	212-718-9005
Primary Physician	Dr. John Smith, NPI: 0000000000	101 Bedford Avenue, Brooklyn, NY	212-718-9006

Emergency Plan & Advance Directives

Emergency Plan Discussed:	☑ Yes ☐ No
Emergency Preparedness:	☑ Medication list current and accessible ☑ Medical equipment backup/alternative plan ☑ Evacuation plan established ☑ 7-day supply of medications available ☑ Emergency phone numbers posted ☑ Medical alert device if needed
Advance Directives:	☐ None ☑ Healthcare Proxy ☐ DNR
Teaching Provided:	I instructed on emergency preparedness, maintaining an updated medication list and adequate supply, equipment backup planning, posting emergency contacts, and evacuation procedures. I also taught the importance of a healthcare proxy and keeping advance care preferences accessible.

Safety Measures / Activities Permitted / Immunizations

Safety Measures:	Fall Precautions, Skin/Pressure Prevention, Emergency Plan, Environment, Aspiration Precautions, DME/Transfer Safety
Activities Permitted:	☑ No Restrictions ☐ Complete Bedrest ☐ Bedrest BRP ☐ Up As Tolerated ☐ Transfer Bed/Chair ☐ Independent At Home ☐ Partial Weight Bearing ☐ Exercises Prescribed ☐ Crutches ☐ Cane ☐ Wheelchair ☐ Walker
Immunizations:	☐ None ☑ Influenza (Date: 2025-11-19) ☐ Pneumonia ☐ COVID-19 ☐ Tetanus ☐ Hepatitis B ☐ Refused
Teaching Provided:	I instructed on the importance of annual influenza vaccination, taught recognition of flu symptoms and when to seek medical care, and educated on flu prevention measures and vaccination benefits.
RN Narrative/Notes:	Patient reports receiving vaccines but is unsure of dates.

Summary

Prognosis:	☑ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Excellent
RN Visit Frequency:	One visit every 180 days
Services Needed:	☐ HHA ☑ PCA
Service Frequency:	7 days x 3 hours
Orders for Discipline and Treatments:	ORDERS: SN to Assess Patient Needs and Appropriateness of Plan of Care. Update Plan of Care As Indicated by Patient Needs, SN for Assessment of: Safety, Personal Care Needs, Medication Regimen and Supervision of HHA/PCA. Assess CV, CP, GI, GU, Endo, Neuro, MS, PV, Skin, Cognitive and Mental Status, Nutrition and Hydration Status, Assess / Instruct On Health Status / Maintenance, Activities Permitted, Safety Measures, And Management. SN to notify MD if heart rate is below 50 or above 120bpm or if blood pressure is less than 90/50 or above 170/100 and if patient reports pain level above 7 with no relief. Notify MD if blood glucose level is below 55mg/DL or above 240mg/DL. Aide Will Perform Personal Care and ADLs As Specified In Plan Of Care.
Goals of Care:	GOALS: Patient Demonstrates Improvement in the Following: Adequate Personal Care, Adequate ADLs, Maintaining Patient Safely in the Home, Will Comply With All Fall Prevention Duties and Safety Precautions, Demonstrates Safety In Mobility, Use Of Adaptive Devices, Understanding Disease Process, Limitations And Medication Regimen, Maintains Optimal Nutrition/Hydration Status, Demonstrates Appropriate Disease Process Management. Aide Demonstrates Improvement in the Following: Adequate Personal Care, Adequate ADLs, Maintaining Patient Safely in the Home, Will Comply With All Fall Prevention Duties and Safety Precautions, Demonstrates Safety In Mobility, Use Of Adaptive Devices, Understanding Disease Process, Limitations And Medication Regimen. Discharge Planning: Patient will continue to receive aide services until no longer required, as ordered by MD
Aide POC completed:	☑ Yes ☐ No
Plan of Care Discussed:	☑ Yes ☐ No
Patient verbalized understanding:	☑ Yes ☐ No

Progress Note

71-year-old female seen for reassessment. Patient lives alone, alert and oriented, ambulates with rollator with very unsteady gait and high fall risk. Undergoing chemotherapy every 3 weeks for metastatic breast cancer; not on other medications. Vitals stable. Denies pain. Exhibits depression related to past losses and ataxia; teaching provided on mood support, social engagement, and safe ambulation. Visual impairment corrected with glasses and bilateral hearing loss noted; educated on home safety and communication strategies. Missing teeth affect chewing; soft diet reviewed. Lungs diminished but no symptoms; instructed on mobility and deep breathing. Weakness, limited ROM, and coordination issues present; reinforced proper use of assistive devices and therapy adherence. Post-mastectomy care discussed. No skin issues. Poor appetite with weight loss; educated on small frequent meals and high-calorie intake. Uses rollator and bathroom safety equipment; safety teaching reinforced. Home heating inadequate; instructed on safe temperature management. Emergency plan reviewed. No immediate concerns.

John Doe
Patient / Representative Signature & Name

02/09/2026
Date

Jane Doe, RN
RN Signature & Name

02/09/2026
Date