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E-CHAT for users in New Mexico

Comprehensive Health Assessment

Reason for Assessment | Date

- ☐ Annual Assessment/ISP ____________
- ☐ New Admission/Agency Transfer ____________
- ☐ Change of Condition ____________
- ☐ Hospital Discharge ____________
- ☐ Hospital Discharge for Aspiration Pneumonia ____________
- ☐ Quarterly Nursing Assessment ____________
- ☐ Other ____________

ISP Effective Date

From: ____________ To: ____________

Date of Assessment: ____________

Diagnoses and Conditions

1. Active Diagnoses:

ICD-10	ICD-9/ DSM-4/ Other	Axis	DSM-5	Description	Diagnosis Date	Diagnosed By

Other Medical Information

Historical/Inactive Diagnoses or Conditions

____

1.a Comments: ____________

2. Allergies:

____

2.a Are there any known allergies to food, environment or drugs? ☐ No ☐ Yes

2.b Is there a known history of anaphylactic reaction? ☐ No ☐ Yes

2.c Comments: ____________

3. Medications:

Begin Date	End Date	Medication Name	Medication Type	Purpose

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3.a Medication Delivery Supports:
☐ Self-Administration of Medications ☐ Self-Administration with Physical Assistance
☐ Assistance with Medication Delivery by Staff ☐ Medication Administration by Licensed or Certified Personnel
● Receives routine injectable medication(s) by ☐ Agency licensed nurse or certified medication aide daily or multiple times per day
☐ Agency licensed nurse or certified medication aide several times a week ☐ Agency licensed nurse or certified medication aide at least once per month
☐ Agency licensed nurse or certified medication aide at least annually or up to once per quarter ☐ Self administration or biological family member at any frequency
☐ Physician, PCP or clinic (loading of pump; intermittent long acting injections)
● Nurse/IDT comments: ____________________

3.b Monitoring Effectiveness of Medications : ____________________

3.c Refusal of Medications, Treatments or Monitoring: ☐ Never or rarely refuses
☐ Occasional refusal that does not impact health ☐ Frequent refusal or occasional refusal that has impact on health
3.d Comments: ____________________

4. Labs/ Radiology:
Any abnormal lab work or radiology exams in the past year? ☐ No ☐ Yes
If Yes, Provide a synopsis of any abnormal lab or radiology finding and activities taken to follow up or address these issues.

____

4.a Currently requires frequent lab tests or radiology exams routinely to manage, monitor or maintain health status. ☐ No ☐ Yes
4.b Comments: ____________________

5. Utilization of Medical Services:

Scheduled visit to PCP in the past year:	☐ 1-4 times	☐ 5-7 times	☐ 8 or more times
5.a Urgent care or Emergency room visit in the past year:	☐ 0-2 times	☐ 3-4 times	☐ 5 or more times
5.b Number of medical hospitalizations in the past year:	☐ 0-1 times	☐ 2-3 times	☐ 4 or more times
5.c Number of psychiatric hospitalizations in the past year:	☐ 0-1 times	☐ 2-3 times	☐ 4 or more times
5.d Number of medical hospitalizations in the last 3 months:	☐ 0 time	☐ 1 time	☐ 2 or more times
5.e Number of psychiatric hospitalizations in the last 3 months:	☐ 0 time	☐ 1 time	☐ 2 or more times
5.f Required Heimlich maneuver or abdominal thrusts to clear airway:	☐ 0 time	☐ 1 time	☐ 2 or more times

5.g Is there an existing diagnosis, a new diagnosis or a condition change that requires frequent medical follow up, treatment or monitoring (i.e. cancer, acute illness)? If Yes, Describe: ☐ No ☐ Yes

____

5.h Comments: ____________________

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6. Vital Signs:

Were vital signs taken at the time of this assessment? ☐ No ☐ Yes

If Yes: Temperature: ________ Blood: ________

Respirations: ________ Blood Pressure: ________

6.a Pulse Oximeter readings ordered? ☐ N/A ☐ No ☐ Yes

If Yes: Most Recent Oximeter Reading: ☐ 02 < 90% ☐ 02 > or = 90% Date and Time: ________

6.b Comments: ________

7. Height and Weight:

Height: ________ Feet ________ Inch Weight: ________ lbs

7.a Has there been unplanned weight gain (> 5 lbs)? ☐ No ☐ Unknown ☐ Yes

7.b Has there been unplanned weight loss? ☐ No ☐ Unknown ☐ Yes

If Yes: ☐ Unplanned loss of less than 5% of total body weight in a 3-month period ☐ Unplanned loss of up to 10% (or higher) of total body weight or 10 lbs in a 6-month period

7.c BMI: ________

7.d Comments: ________

8. Nutrition:

- Does the individual receive a special diet? ☐ No ☐ Yes
- Diet Order: ☐ Regular ☐ NPO ☐ Diabetic Calories: ________ ☐ High Calorie Calories: ________
  ☐ Low Salt ☐ Low Fat ☐ Ketogenic ☐ Gluten Free ☐ Other: ________
- Diet Texture: ☐ Regular ☐ Chopped ☐ Mechanical Soft ☐ Pureed ☐ Other: ________
- Fluid Consistency: ☐ Regular/thin Liquids ☐ Nectar thickened ☐ Honey thickened
  ☐ Pudding thickened ☐ Others: ________

8.a Does individual require fluid restriction? ☐ No ☐ Yes

8.b Does individual require supports to assure adequate hydration or minimize risk of dehydration?

☐ No Supports ☐ Occasional Supports ☐ Frequent - Daily Supports

8.c Is intake and output monitoring ordered by a PCP/Specialist?

☐ No ☐ Yes ☐ Intake Only ☐ Output Only ☐ Both Intake and Output

8.d Comments: ________

9. Tube Feeding/ Eternal Nutrition:

- Does individual receive tube feeding or enteral nutrition? ☐ No ☐ Yes
- Tube Type: ☐ NG ☐ G Tube ☐ G/J tube ☐ J Tube
- Tube Details: ☐ PEG ☐ Mic-Key ☐ Button/low profile ☐ Balloon tip (foley) ☐ Other: ________
- Original tube placement date: ________
- Tube last replaced: ________

9.a Tube site information at time of assessment: ☐ Site clean and dry ☐ Healthy pink stoma

☐ Reddened skin around stoma ☐ Macerated skin around stoma ☐ Retracted stoma ☐ Retracted tube or button

☐ Leaking formula ☐ Purulent drainage ☐ Erosion at site ☐ Fistula at site

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- Describe additional condition of tube and site, as well as any ongoing concerns

____

9.b Risk for tube displacement: ☐ Never or rarely touches ☐ Often touches or pulls ☐ Pulls out tube

9.c Comments: ______________________________

10. Aspiration Risk:

- Aspiration Risk as determined by Screening Tool: ☐ Low ☐ Moderate ☐ High

10.a Comments: ______________________________

11. Oral Dental:

Level of assistance with oral care/hygiene: ☐ Independent ☐ With some assistance ☐ Extensive assistance, total dependence

11.a Status of oral care/hygiene: based on dental report or observation ☐ Good oral hygiene ☐ Bad breath

☐ Fair oral hygiene ☐ Poor oral hygiene ☐ Excessive plaque ☐ Multiple cavities ☐ Obvious decay

☐ Broken teeth ☐ Inflamed gums ☐ Bleeding gums ☐ Periodontal disease ☐ Loose teeth

☐ Edentulous (no teeth) ☐ Uses dentures or partial plates

11.b Comments: ______________________________

12. Neurological Signs and Symptoms:

- Is cerebral shunt in place? ☐ No ☐ Yes Date Inserted (If known) __________
- Is baclofen pump in place? ☐ No ☐ Yes Date Inserted (If known) __________
- Is vagal nerve stimulator (VNS) in place? ☐ No ☐ Yes Date Inserted (If known) __________
  Model or type (if known) __________
- Other devices or implants? ☐ No ☐ Yes Date Inserted (If known) __________

Comments: ______________________________

12.a Are signs and symptoms of recent neurological changes present? ☐ No ☐ Yes

12.b Is there a seizure disorder? ☐ No ☐ Yes ☐ Unknown

- Types of seizures usually seen ☐ None ☐ Absence (petit mal) ☐ Atypical absence ☐ Atonic

☐ Clonic ☐ Febrile ☐ Focal ☐ Generalized ☐ Myoclonic (brief muscle jerking)

☐ Tonic-clonic (grand mal) ☐ Psychogenic ☐ Secondary Generalized ☐ Simple Partial ☐ Complex Partial

☐ Other: __________

- Frequency of seizures: ☐ History of seizures but no recent reports of seizure activity

☐ No seizures in the past year ☐ 1 seizure in the past year ☐ Several times per year

☐ Several times per month ☐ At least weekly ☐ Daily or multiple times per day

☐ Multiple times per hour

- Any change in the frequency of seizures over the last several months: ☐ No Change ☐ Yes
  If Yes: ☐ Increase ☐ Decrease
- Status epilepticus in last 12 months? ☐ No ☐ Yes

If Yes, Describe, include cause/trigger if known: ______________________________

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Comments: ____________________

12.c Is paralysis present? ☐ No ☐ Yes
If Yes: ☐ Paraplegic ☐ Quadriplegic ☐ Hemiplegic Left ☐ Hemiplegic Right
Describe: ____________________

12.d Diagnosis of autonomic dysreflexia? ☐ No ☐ Yes
If Yes, Describe: ____________________

12.e Diagnosis of Alzheimer's Disease or other dementias? ☐ No ☐ Yes

12.f Other neurological disorders or events that may require planning? ☐ No ☐ Yes
If Yes, Describe: ____________________

13. Cardiac/ Circulatory/ Blood Disorders:

- Is there a known cardiac or circulatory condition (i.e. hypertension, heart valve disease, or conditions associated with specific syndromes)? ☐ No ☐ Yes

If Yes:
☐ Cardiac/circulatory condition is stable on current treatment plan (medication, diet, activity level, and/or other interventions)
☐ Cardiac/circulatory condition is not stable or has resulted in limitations at work, home or leisure

13.a Is a pacemaker in place? ☐ No ☐ Yes
If Yes: Date Inserted (If known): ____________ Model or type (if known): ____________
13.b Is an implantable cardioverter defibrillator (ICD) in place? ☐ No ☐ Yes
If Yes: Date Inserted (If known): ____________ Model or type (if known): ____________
13.b Is an implantable cardioverter defibrillator (ICD) in place? ☐ No ☐ Yes
If Yes: Date Inserted (If known): ____________ Model or type (if known): ____________
13.c Other cardiac disorders that may require planning? ☐ No ☐ Yes
If Yes, Describe: ____________________
13.d Are there any current blood/hematological disorders (such as anemia, leukemia, clotting, etc) that may require medications, monitoring or planning? ☐ No ☐ Yes If Yes, Describe:
____

13.e Comments: ____________________

14. Endocrine:

- Has the individual been diagnosed with diabetes? ☐ No ☐ Yes

If Yes: ☐ Type 1 ☐ Type 2

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14.a Can individual independently complete all or part of their own blood glucose monitoring? ☐ No ☐ Yes ☐ N/A
14.b Can individual complete self-administration of insulin? ☐ No ☐ Yes ☐ N/A
14.c Does individual experience hypoglycemia? ☐ No ☐ Yes ☐ Irregular pattern of hypo/hyperglycemia
14.d A1c Levels: ☐ A1c levels not available ☐ A1c > 6 ☐ A1c = 6 or higher
14.e Diabetes Comments: ____________________

14.f Other endocrine disorders that may require planning? ☐ No ☐ Yes
If Yes, Describe: ____________________

14.g Comments: ____________________

15. Renal:

- Kidney/renal disorders that may require planning? ☐ No ☐ Yes If Yes, Describe: ____________________

15.a Dialysis: any type ☐ No ☐ Yes If Yes: ☐ Peritoneal ☐ Hemodialysis
15.b Comments: ____________________

16. Gastrointestinal:

- Is there a known gastrointestinal condition? ☐ No ☐ Yes

16.a Receives medication for reflux or GERD? ☐ No ☐ Yes

16.b Complains of or demonstrates signs/symptoms of reflux? ☐ None ☐ Complains of ☐ Demonstrates
If Complains: ☐ Heartburn ☐ Indigestion ☐ Abdominal pain ☐ Vomiting
If Demonstrates (observed or reported) ☐ Biting hand ☐ Arching back ☐ Touching stomach ☐ Food/formula in mouth ☐ Vomiting ☐ Coughing while lying down
16.c Has Celiac disease or gluten sensitivity? ☐ No ☐ Yes

16.d Constipation Management ☐ No issues with constipation ☐ Receives routine medications or treatments for constipation
☐ Regularly utilizes PRN medications or treatments (i.e. enema, suppository) for constipations
☐ Has had impaction or bowel obstruction in the last year
16.e Has diagnosis of PICA (history or active)? ☐ No ☐ Yes ☐ Unknown
16.f Comments: ____________________

17. Bowel and Bladder:

- Bowel Function: ☐ Continent ☐ Sometimes incontinent ☐ Always incontinent
- Bladder Function: ☐ Continent ☐ Sometimes incontinent ☐ Always incontinent

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17.a Colostomy/Ileostomy: ☐ No ☐ Yes

If Yes: ☐ New colostomy/ileostomy (in the past year) ☐ Colostomy/ileostomy stable/no issues with management
☐ Individual exhibits challenging behavior that impacts colostomy/ileostomy care

Comments: ____

____

____

17.b Other bowel and bladder concerns ☐ None ☐ Reported or observed bleeding in urine

☐ Reported or observed rectal bleeding ☐ Urinary catheter - intermittent: ☐ Self ☐ Staff

☐ Urinary catheter - Texas or external ☐ Urinary catheter - Indwelling ☐ Suprapubic/ nephrostomy/ Indiana pouch

☐ Urinary retention or BPH ☐ Frequent Diarrhea ☐ Other: ____________

17.c Comments: ____

____

____

18. Reproductive Health:

- Is the individual sexually active? ☐ No ☐ Yes ☐ Unknown
- Interested in information about birth control? ☐ No ☐ Yes
- Interested in attending sexuality classes? ☐ No ☐ Yes

Women Only (Choose all that apply): ☐ No reproductive health concerns ☐ Pregnant ☐ Menopausal
☐ Reported or observed abnormal vaginal bleeding or discharge
☐ Reported or observed abnormal breast lesions, lumps or discharge

- Date of last Pap smear if ordered by a physician or description of other monitoring in place: ____________
- Date of last Mammogram if ordered by a physician or Description of other monitoring in place: ____________
- Date of last PSA if ordered by a physician or description of other monitoring in place: ____________

Men Only:

- PSA ordered more than once a year? ☐ No ☐ Yes

18.a Cancer history requiring follow up care? ☐ No ☐ Yes

18.b Comments: ____

____

____

19. Behavior Symptoms and Management:

- Has there been a recent change in behavior symptoms that may be caused by a medical condition? ☐ No ☐ Yes

If Yes, Describe: ____

____

19.a Numbers of psychoactive or other classes of medications that are intended to influence Behavior symptoms?

☐ None ☐ 1-2 medications ☐ 3-4 medications ☐ 5 or more medications

19.b Newly reported or observed sign of extrapyramidal symptoms (ESP) involuntary movement disorders? ☐ No ☐ Yes

19.c History of neuroleptic malignant syndrome? ☐ No ☐ Yes

Name of Medication (If known) ____

19.d History of neuroleptic malignant syndrome? ☐ Never ☐ 1-5 ☐ 6-10 ☐ 11 or more

19.e Comments: ____

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20. Infection Control:

- Colonized with multidrug-resistant organism? ☐ No ☐ Yes

20.a Infected with multidrug-resistant organism? ☐ No ☐ Yes

20.b Known chronic viral infection such as hepatitis or other blood borne pathogens? ☐ No ☐ Yes

20.c Other infectious process or disease required planning? ☐ No ☐ Yes - Describe:

20.d Comments:

21. Respiratory:

- Known respiratory condition/ diagnosis: ☐ No ☐ Yes

Indicate all that apply: ☐ None below apply ☐ Cupping/Clapping/Postural Drainage

☐ Oxygen use via cannula or mask ☐ Oxygen use via trach ☐ Oral and/or pharyngeal suctioning

☐ Tracheal suctioning ☐ Tracheotomy ☐ Ventilator ☐ Percussion Vest ☐ Refuses oxygen use

Other:

- If on oxygen, indicate number of liters: ______

Nebulizer treatments ☐ No ☐ Yes If Yes, frequency: ☐ PRN ☐ At least weekly ☐ Daily/more often

- Has CPAP/BiPAP devices ordered (drop down): ☐ No devices Ordered ☐ Uses regularly ☐ Refuses to use
- Other respiratory issues requiring planning? ☐ No ☐ Yes - Describe:

21.a Comments:

22. Communication/ Vision/ Hearing:

- Able to make need known? ☐ Yes Verbal ☐ Yes w/out devices ☐ Yes w/ devices ☐ No

22.a Known Visual impairment (Choose all that apply): ☐ None ☐ Uses glasses or contacts

☐ Refuses glasses or contacts ☐ Complete visual impairment or cortical blindness ☐ Other:

22.b Known Hearing Impairment (Choose all that apply): ☐ None ☐ Uses Aide(s) ☐ Refuses aide(s)

☐ Uses ASL, gestures or devices ☐ Other

22.c Comments:

23. Musculoskeletal/Neuromuscular:

- Musculoskeletal or neuromuscular disorders that may require planning? ☐ No ☐ Yes - Describe:

23.a Fracture in the last year? ☐ No ☐ Yes - Status

23. b Spasticity or contractures require routine interventions to maintain positioning, minimize pressure and support comfort and safety ☐ No ☐ Yes

23.c Change or decline in functional ability in last year? ☐ No ☐ Yes

23.d Comments:

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24. Falls:

● Number of fall(s) in the last year? ☐ None ☐ 1-2 falls ☐ 3 or more falls

● Did any fall result in injury that required medical treatment in urgent care or emergency room? ☐ No ☐ Yes

24.a Comments: ____

25. Pain:

● Currently experiencing pain: ☐ No ☐ Nonverbal and may be experiencing pain ☐ Yes (If Yes, specify below)

☐ Controlled with medication or treatment ☐ Partial or poor control with medication or treatment ☐ Not controlled with medication or treatment

25.a Nonverbal and may be experiencing pain: Observed or reported expressions of pain

☐ Does not appear to be in distress; relaxed, not crying ☐ Occasionally grimaces; whimpers; restless or tense; able to calm or reassure

☐ Frequent grimace or frowns; obvious physical distress; may be rigid or jerking; crying, moaning, unable to comfort, hitting self or others, or unique actions known to be that person's way of communicating pain or distress

25.b Receives pain medication? ☐ No ☐ Self administers all pain medication

☐ Yes and requires assistance or administration of medication ☐ If Yes, specify below:

☐ PRN 3 times per month or less ☐ PRN 1 time per week ☐ PRN 2 or more times per week

☐ PRN daily or several times per day

25.c Comments: ____

26. Activities of Daily Living:

● Level of assistance with grooming/dressing ☐ Independent or minimal assistance

☐ Moderate assistance and/or requires adaptive equipment ☐ Totally dependent

● Level of assistance with hygiene/bathing ☐ Independent or minimal assistance

☐ Moderate assistance and/or requires adaptive equipment ☐ Totally dependent

● Level of assistance with transfer/mobility ☐ Independent or minimal assistance

☐ Moderate assistance and/or requires adaptive equipment ☐ Totally dependent ☐ Bedbound

● Individual is non-ambulatory and prefers to spend majority of time on the floor ☐ No ☐ Yes

26.a Comments: ____

27. Skin and Wound:

● Choose the applicable statement:

☐ Answer in above section for transfer/mobility was independent or minimal assistance and there is no known history of pressure ulcers

☐ pendent or minimal assistance and there is a known history of pressure ulcers

☐ Answer in above section for transfer/mobility was moderate assistance/requires adaptive equipment or totally dependent

● Conditions (Choose all that apply): ☐ Underweight by standard ☐ Incontinent of bowel, bladder or both

☐ Shearing forces in bed or chair ☐ Contractures ☐ Fixed deformity (kyphosis/scoliosis) ☐ Neuropathy

☐ History of pressure ulcers (now healed) ☐ Altered consciousness (lethargic, difficult to rouse)

Open skin areas: ☐ None ☐ Pressure ulcers ☐ Vascular ulcers

Other open skin areas (surgical sites/cuts/lacerations/erosions): ______________________________

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- Treatments for open skin areas: ☐ N/A ☐ Routine treatments ordered (aseptic) ☐ Sterile Treatments
☐ Complex treatments ordered (wound vac, etc)
- Other Skin Conditions?: ☐ No ☐ Yes

27.a Skin integrity: Individual is ☐ Frequently outdoors and refuses screen/protective clothing ☐ Sun sensitive
☐ Engages in self injurious behavior, such as picking, scratching etc ☐ Incontinent/requires preventive skin care
27.b Comments (include description of routine or PRN topical treatments and preventive skin care here): ____________________

____

____

28. Health Practices:

- Is individual receptive to participating in the development of goals and plans related to maintaining their health? ☐ No ☐ Yes

28.a Uses tobacco/nicotine products: ☐ Does not use tobacco/nicotine products ☐ Unknown status
☐ Smokes cigarettes or cigars ☐ Uses cig (electronic) ☐ Uses chewing tobacco ☐ Uses nicotine patch/gum
☐ Unsafe smoking - requires supervision or smoking apron to prevent accidental injury
28.b Uses street drugs/prescription drug abuse ☐ Does not use ☐ Unknown Status
☐ Currently known to use ☐ Past history of street drug use/prescription
28.c Currently uses alcohol with a diagnosis of alcoholism? ☐ No ☐ Yes ☐ Unknown
28.d Has difficulty tolerating routine adult healthcare screening? ☐ No ☐ Yes - Describe

____

28.e Requires pre-sedation/medical stabilization for medical visits or appointments ☐ No ☐ Yes

28.f Have health issues prevented desired level of participation in work or community inclusion activities? ☐ No ☐ Yes
28.h Receiving hospice services or palliative care? ☐ No ☐ Yes
28.i Comments: ____________________

____

____

29. Other Comments: ____________________

____

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