TEXAS Department of Aging and Disability Services

Form 3050
October 2015-E

Day Activity and Health Services (DAHS)

# Health Assessment/Individual Service Plan

## Section I – Identification and Background Information

| Individual Name – (Last, First, Middle Initial) | | | | Date of Birth |
|---|---|---|---|---|
| Individual's Number | Current Date of Eligibility | Sex ☐ Male ☐ Female | Lives Alone ☐ Yes ☐ No | Reason for Assessment ☐ Initial ☐ Change ☐ Ongoing |
| DAHS Facility Name | | DAHS Nurse | | DAHS Area Code and Telephone No. |
| DAHS Facility Address (Street, City, State and ZIP Code) | | | | |

D.A.H.S. Facility Address. Street, City, State and ZIP Code.

## Section II – Assessment of Functional/Physical Status

Indicate Problems/Conditions/Symptoms experienced within the last 30 days. Check all that are present. Enter a comment as needed for boxes checked (i.e., frequency, location, etc.). Additional space for comments is available at the end of Section II.

A. Alteration in Nutrition/Metabolism

| | | |
|---|---|---|
| ☐ Choking, risk of aspiration | ☐ Low body weight | ☐ Inadequate fluid intake |
| ☐ Inadequate nutritional intake | ☐ Upset stomach/indigestion | ☐ Intake exceeds body's needs |
| ☐ Blood sugar fluctuations or abnormalities | ☐ Chewing Problem | ☐ Swallowing problem |
| ☐ Uses dentures | ☐ Some or all natural teeth lost – does not have/use or partial plates | |
| ☐ Other/Specify): | | ☐ N/A |

B. Alteration in Elimination

| | | |
|---|---|---|
| ☐ Constipation | ☐ Diarrhea | ☐ Bladder incontinence program |
| ☐ Bladder incontinence | ☐ Bowel incontinence | ☐ Bowel incontinence program |
| ☐ Other/Specify): | | ☐ N/A |

C. Alteration in Cardiac/Respiratory Status

| | | | |
|---|---|---|---|
| ☐ Chest Pain | ☐ Cyanosis | ☐ Oxygen use | ☐ Blood Pressure fluctuations/abnormalities |
| ☐ Wheezing | ☐ Shortness of breath | ☐ Peripheral circulation issues (including edema) | |
| ☐ Other/Specify): | | | ☐ N/A |

D. Alteration in Skin

| | | |
|---|---|---|
| ☐ Pressure ulcer | ☐ Stasis ulcer | ☐ Lesion other than pressure/status ulcer, including feet |
| ☐ Surgical Wound | ☐ Risk of skin breakdown | ☐ Swelling |
| ☐ Fragile skin | ☐ Rash | |
| ☐ Skin desensitized to pain or pressure | ☐ Abrasions, bruises | |
| ☐ Other/Specify): | | ☐ N/A |

E. Alteration/Deficit in Body Control

| | | | |
|---|---|---|---|
| ☐ Unsteady gait | ☐ Amputation | ☐ Balanced – partial/total loss of ability to balance while standing | |
| ☐ Quadriplegia | ☐ Hemiplegia/hemiparesis | ☐ Lack of hand dexterity (ie: problem using utensils) | |
| ☐ Uses ambulation device | ☐ Paraplegia | ☐ Arm/Leg/trunk – Part or total loss of Voluntary movement | |
| ☐ Other/Specify): | | ☐ Contractures | ☐ N/A |

F. Alteration in Neurological Status

| | | | | |
|---|---|---|---|---|
| ☐ Seizures ☐ Tremors | ☐ Generalized weakness | ☐ Dizziness vertigo | ☐ Not oriented X3 | |
| ☐ Limitations in cognition | ☐ Other: | | ☐ N/A | |

G. Altered Sensory.Perceptual Awareness

- ☐ Pain
- ☐ Wears glasses or contacts
- ☐ Hearing deficit – minimally impaired
- ☐ Vision deficit – minimally impaired
- ☐ Hearing deficit – highly impaired
- ☐ Vision deficit – highly impaired
- ☐ Wears hearing aid
- ☐ Other/Specify):
- ☐ N/A

H. Communications Deficits

- ☐ Difficulty making self understood, Limited to
- ☐ Difficulty understanding
- ☐ May miss intent or message
- ☐ Making concrete requests, Difficulty finding
- ☐ Rarely/never understands
- ☐ Only sometimes understands
- ☐ Wording/finishing thoughts
- ☐ N/A
- ☐ Other:

I. Behavior Challenges

Specify other.

- ☐ Wandering
- ☐ Motor agitation
- ☐ Failure to eat or take medication
- ☐ Socially inappropriate or disruptive behaviors
- ☐ Other:
- ☐ N/A

J. Vital Signs/Height/Weight/Blood Sugar

| Blood Pressure | Pulse | Respiration | Temp. (optional) | Height | Weight | Blood Sugar (optional) |
|---|---|---|---|---|---|---|
| | | | | | | |

Additional Comments:

## Section III – Therapies and Treatments

Check therapies the individual is **currently** receiving from **any** source.

- ☐ Speech – language pathology, audiology services
- ☐ Physical Therapy
- ☐ Psychology Therapy (licensed professional)
- ☐ Occupational Therapy
- ☐ Respiratory Therapy
- ☐ Radiation
- ☐ Chemotherapy
- ☐ Dialysis
- ☐ Other:

## Section IV – Plan of Care: Personal Care at the DAHS Facility

Check the appropriate boxes if assistance with the task will be provided at the DAHS facility.

**A. Transfer** ☐ **No Assistance Needed**

| Assistance Needed | Schedule/Frequency | Comments |
|---|---|---|
| ☐ Setup Required | | |
| ☐ One-Person Physical Assistance | | |
| ☐ Two-Person Physical Assistance | | |

Option 2 of 3, One-Person Physical Assistance

**B. Ambulation** ☐ **No Assistance Needed**

Individual Uses the Following Aids: ☐ Cane ☐ Walker ☐ Wheelchair-Self ☐ Wheelchair-Assisted

| Assistance Needed | Schedule/Frequency | Comments |
|---|---|---|
| ☐ Setup Required | | |
| ☐ One-Person Physical Assistance | | |
| ☐ Two-Person Physical Assistance | | |

| Individual Name – (Last, First, Middle Initial) | Date of Birth | Individual's Number |
|---|---|---|
| | | |

**C. Eating** ☐ **No Assistance Needed**

Individual Uses the Following Aids: ☐ Feeding Tube ☐ Syringe (Oral Feeding) ☐ Plate Guard, Stabilized Built-Up Utensil, etc.
☐ Other:

| Assistance Needed | Schedule/Frequency | Comments |
|---|---|---|
| ☐ Setup Required | | |
| ☐ One-Person Physical Assistance | | |
| ☐ Two-Person Physical Assistance | | |

**D. Toileting** ☐ **No Assistance Needed**

Individual Uses the Following Aids: ☐ External (condom) Catheter ☐ Indwelling Catheter ☐ Intermittent Catheter ☐ Pads, Diapers

Toileting Program: ☐ Yes ☐ No ☐ Ostomy ☐ Enema, Irrigation

| Assistance Needed | Schedule/Frequency | Comments |
|---|---|---|
| ☐ Setup Required<br>Option 1 of 3, setup required | | |
| ☐ One-Person Physical Assistance | | |
| ☐ Two-Person Physical Assistance | | |

**E. Bathing** ☐ **No Assistance Needed**

Individual Uses the Following Aids: ☐ Shower Chair ☐ Transfer Bench ☐ Handheld Shower Wand ☐ Sponge Bath

| Assistance Needed | Schedule/Frequency | Comments |
|---|---|---|
| ☐ Setup Required | | |
| ☐ One-Person Physical Assistance | | |
| ☐ Two-Person Physical Assistance | | |

**F. Dressing and Grooming** ☐ **No Assistance Needed**

Individual Uses the Following Aids: ☐ Shaving ☐ Hair Care ☐ Brushing Teeth ☐ Nail Care ☐ Dressing

| Assistance Needed | Schedule/Frequency | Comments |
|---|---|---|
| ☐ Setup Required | | |
| ☐ One-Person Physical Assistance | | |
| ☐ Two-Person Physical Assistance<br>Option 3 of 3, Two-Person Physical Assistance | | |

**G. Assistance with Self-Administer Medication While Attending DAHS** ☐ **No Assistance Needed**

Individual Needs Assistance with Self-administering Medication

| Medications | Schedule/Frequency | Comments |
|---|---|---|
| | | |
| | | |
| | | |

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| Individual Name – (Last, First, Middle Initial) | Date of Birth | Individual's Number |
|---|---|---|
| | | |



## Section V – Therapeutically Benefit

This individual will benefit therapeutically from DAHS by:

Additional Information/Notes:

## Section VI – Participation in Assessment

Additional inform

| Individual | Family | Significant Other | Responsible Party |
|---|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

Comments:

Signature – Individual or Responsible Person

Date

I certify this individual has a chronic medical condition and will benefit therapeutically from DAHS.

Signature – Nurse Completing Form

Date Assessment Completed

Printed Name – Nurse Completing Form

Area Code and Telephone Number

Print Form  Reset Form