

0. Cover Sheet

0.A. INDIVIDUAL IDENTIFICATION

0. ILA is being completed for which (DAIL) program?

- A - Adult day
- B - ASP
- C - HASS
- D - Homemaker
- E - Medicaid Waiver (Choices for Care)
- F - AAA services (NAPIS)
- G - Other
- H - Dementia Respite

1. Date of assessment?

____ / ____ / ____

2. Unique ID# for client.

3.a. Client's last name?

3.b. Client's first name?

3.c. Client's middle initial?

4. Client's telephone number.

5. Client's Social Security Number?

____ - ____ - ____

6. Client's date of birth?

____ / ____ / ____

7. Client's gender?

- M - Male
- F - Female
- T - Transgendered

8.a. Client's mailing street address or Post Office box.

8.b. Client's mailing city or town.

8.c. Client's mailing state.

8.d. Client's mailing ZIP code.

9.a. Residential street address or Post Office box.

9.b. Residential city or town.

9.c. Client's state of residence.

0.B. ASSESSOR INFORMATION

4. Agency the assessor works for?

5. ILA completed by? (name of assessor)

0.C. EMERGENCY CONTACT INFORMATION

1.a. Emergency Contact 1

1.b. Phone number of Emergency Contact # 1?

1.c. Street address of Emergency Contact #1

1.d. City or town of Emergency Contact #1?

1.e. State of Emergency Contact #1

1.f. Zip code for Emergency contact #1?

1.g. Emergency Contact #1's relationship to client

2.a. Name of Emergency Contact #2?

2.b. Phone number of the client's Emergency Contact #2?

2.c. Street address or P.O box of the client's emergency contact #2?

2.d. City or town of the client's emergency contact #2?

2.e. State of client's Emergency Contact #2?

2.f. ZIP code of the client's emergency contact #2?

3.a. Client's primary care physician?

3.b. Phone number for the client's primary care physician?

4. Does the client know what to do if there is an emergency?

- A - Yes
 B - No

5. In the case of an emergency, would the client be able to get out of his/her home safely?

- A - Yes
 B - No

6. In the case of an emergency, would the client be able to summon help to his/her home?

- A - Yes
 B - No

7. Does the client require immediate assistance from Emergency Services in a man-made or natural disaster?

- A - Yes
 B - No

8. Who is the client's provider for emergency response services?

9. Comments regarding Emergency Response

O.D. DIRECTIONS TO CLIENT'S HOME

Directions to client's home.

5. Health Assessment (for CFC must be completed by RN/LPN)

5.A. Diagnosis/Conditions/Treatments

1. Describe the client's primary diagnoses.

2. Indicate which of the following conditions/diagnoses the client currently has.

- A - ENDOCRINE-Diabetes
- B - ENDOCRINE-Hyperthyroidism
- C - ENDOCRINE-Hypothyroidism
- D - HEART-Arteriosclerotic heart disease (ASHD)
- E - HEART--Cardiac dysrhythmias
- F - HEART--Congestive heart failure
- G - HEART--Deep vein thrombosis
- H - HEART--Hypertension
- I - HEART--Hypotension
- J - HEART--Peripheral vascular disease
- K - HEART-Other cardiovascular disease
- L - MUSCULOSKELETAL-Arthritis/rheumatic disease/gout
- M - MUSCULOSKELETAL-Hip fracture
- N - MUSCULOSKELETAL-Missing limb (e.g., amputation)
- O - MUSCULOSKELETAL-Osteoporosis
- P - MUSCULOSKELETAL-Pathological bone fracture
- Q - NEUROLOGICAL-Alzheimer's disease
- R - NEUROLOGICAL-Aphasia
- S - NEUROLOGICAL-Cerebral palsy
- T - NEUROLOGICAL-Stroke
- U - NEUROLOGICAL - Non-Alzheimer's dementia
- V - NEUROLOGICAL-Hemiplegia/Hemiparesis
- W - NEUROLOGICAL-Multiple sclerosis
- X - NEUROLOGICAL-Paraplegia
- Y - NEUROLOGICAL-Parkinson's disease
- Z - NEUROLOGICAL-Quadriplegia
- AA - NEUROLOGICAL-Seizure disorder
- BB - NEUROLOGICAL-Transient ischemic attack
- CC - NEUROLOGICAL-Traumatic brain injury
- DD - PSYCHIATRIC-Anxiety disorder
- EE - PSYCHIATRIC-Depression
- FF - PSYCHIATRIC- Bipolar disorder (Manic)
- GG - PSYCHIATRIC-Schizophrenia
- HH - PULMONARY-Asthma
- II - PULMONARY-Emphysema/COPD/
- JJ - SENSORY-Cataract

- KK - SENSORY-Diabetic retinopathy
- LL - SENSORY-Glaucoma
- MM - SENSORY-Macular degeneration
- MM1 - SENSORY - Hearing impairment
- NN - OTHER-Allergies
- OO - OTHER-Anemia
- PP - OTHER-Cancer
- QQ - OTHER-Renal failure
- RR - None of the Above
- SS - OTHER-Other significant illness

2.a. Enter any comments regarding the client's medical conditions/diagnoses.

3. Select all infections that apply to the client's condition based on the client's clinical record, consult staff, physician and accept client statements that seem to have clinical validity. Do not record infections that have been resolved.

- A - Antibiotic resistant infection (e.g.,Methicillin resistant staph)
- B - Clostridium difficile (c.diff.)
- C - Conjunctivitis
- D - HIV infection
- E - Pneumonia
- F - Respiratory infection
- G - Septicemia
- H - Sexually transmitted diseases
- I - Tuberculosis
- J - Urinary tract infection in last 30 days
- K - Viral hepatitis
- L - Wound infection
- M - None
- N - Other

4. Indicate what problem conditions the client has had in the past week.

- A - Dehydrated; output exceeds input
- B - Delusions
- C - Dizziness or lightheadedness
- D - Edema
- E - Fever
- F - Internal bleeding
- G - Recurrent lung aspirations in the last 90 days
- H - Shortness of breath
- I - Syncope (fainting)
- J - Unsteady gait

4. Indicate what problem conditions the client has had in the past week.

- K - Vomiting
- L - End Stage Disease (6 or fewer months to live)
- M - None of the above
- N - Other

5. Medical treatments that the client received during the last 14 days.

- A - TREATMENTS - Chemotherapy
- B - TREATMENTS - Dialysis
- C - TREATMENTS - IV medication
- D - TREATMENTS - Intake/output
- E - TREATMENTS - Monitoring acute medical
- F - TREATMENTS - Ostomy care
- G - TREATMENTS - Oxygen therapy
- H - TREATMENTS - Radiation
- I - TREATMENTS - Suctioning
- J - TREATMENTS - Tracheostomy care
- K - TREATMENTS - Transfusions
- L - TREATMENTS - Ventilator or respirator
- M - None of the Above
- N - Other

6. Indicate all therapies received by the client in the last seven (7) days.

- A - Speech therapy
- B - Occupational therapy
- C - Physical therapy
- D - Respiratory therapy
- E - None of the above

7. Does the client currently receive at least 45 minutes per day for at least 3 days per week of PT or a combination of PT, ST or OT?

- A - Yes
- B - No
- C - Information unavailable

8. Select all that apply for nutritional approaches.

- A - Parenteral/IV
- B - Feeding tube
- C - Mechanically altered diet
- D - Syringe (oral feeding)
- E - Therapeutic diet
- F - Dietary supplement between meals
- G - Plate guard, stabilized built-up utensil, etc
- H - On a planned weight change program
- I - Oral liquid diet
- J - None of the above

9. Select all that apply with regards to the client oral and dental status.

- A - Broken, loose, or carious teeth
- B - Daily cleaning of teeth/dentures or daily mouth care —by Client or staff
- C - Has dentures or removable bridge
- D - Inflamed gums (gingiva);swollen/bleeding gums; oral abscesses; ulcers or rashes
- E - Some/all natural teeth lost, does not have or use dentures or partial plate
- F - None of the above

10. High risk factors characterizing this client?

- A - Smoking
- B - Obesity
- C - Alcohol dependency
- D - Drug dependency
- E - Unknown
- G - None of the above

5.B. Pain Status

1. Indicate the client's frequency of pain interfering with his or her activity or movement.

- A - No pain
- B - Less than daily
- C - Daily, but not constant
- D - Constantly

2. If the client experiences pain, does its intensity disrupt their usual activities? (e.g. sleep, eating, energy level)

- A - Yes
- B - No

5.C. Skin Status

ULCER KEY.

STAGE 1: Persistent area of skin redness(no break in skin) that doesn't disappear when pressure is relieved

STAGE2: Partial skin thickness loss, presents as an abrasion, blister, or shallow crater.

STAGE3: Full skin thickness loss, exposing subcutaneous tissues, presents as a deep crater.

STAGE 4: Full skin thickness loss, exposing subcutaneous tissues, exposing muscle or bone.

1.a. Specify the highest ulcer stage (1-4) for any pressure ulcers the client has (specify 0 if the client has no pressure ulcers).

1.b. Specify the highest ulcer stage (1-4) for any stasis ulcers the client has (specify 0 if the client has no pressure ulcers).

2. Indicate which of the following skin problems the client has that requires treatment.

- A - Abrasions or Bruises
- B - Burns (second or third degree)
- C - Open lesions other than ulcers, rashes or cuts
- D - Rashes
- E - Skin desensitized to pain or pressure
- F - Skin tears or cuts
- G - Surgical wound site
- H - None of the above

5.D. Elimination Status

1. Has this client been treated for a urinary tract infection in the past 14 days?

- A - Yes
- B - No

2. Describe the client's urinary incontinence or urinary catheter presence. Client is continent if dribble volume is insufficient to soak through underpants with appliances used (pads or continence program)

- A - Yes Incontinent
- B - No incontinence nor catheter
- C - No incontinence has Urinary catheter

3. What is the frequency of bladder incontinence?

- A - Incontinent, Less than weekly
- B - One to three times weekly
- C - Four to six times weekly
- D - One to three times daily
- E - Four or more times daily

4. When does bladder (urinary) incontinence occur?

- A - During the day only
- B - During the night only
- C - During the day and night

5. What is the current state of the client's bowel continence (in the last 14 days, or since the last assessment if less than 14 days)? Client is continent if control of bowel movement with appliance or bowel continence program.

- A - Incontinent
- B - No incontinence nor ostomy
- C - No Incontinence has ostomy

6. What is the frequency of bowel incontinence?

- A - Less than once weekly
- B - One to three times weekly
- C - Four to six times weekly
- D - One to three times daily
- E - Four or more times daily

7. When does bowel incontinence occur?

- A - During the day only
- B - During the night only
- C - During the day and night

8. Has the client experienced recurring bouts of diarrhea in the last seven (7) days?

- A - Yes
- B - No

9. Has the client experienced recurring bouts of constipation in the last seven (7) days?

- A - Yes
- B - No

Comments regarding Urinary/Bowel Problems

5.E. Comments and RN/LPN Signature

Comments regarding Medical Conditions

Enter the name of the Agency of the LPN/RN .

What is the name of LPN/RN who completed Health Assessment section. SIGN BELOW