

Ohio Department of Medicaid  
**Private Duty Nursing (PDN) Assessment**

Assessment Date	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Nurse (print)	
<b>Consumer Information</b>			
Name First	Middle	Last	
DOB	Medicaid Number	Spend Down Amount	
County	Phone Number	Alternate Phone Number	
Address		City	
<b>Client Lives With</b>			
Mother's Name	Address (if different)	Phone (if different)	
Father's Name	Address (if different)	Phone (if different)	
Guardian / POA/ Authorized Rep	Address	Phone	
Emergency Contact Name	Address	Phone	
Siblings/Others in Home	Relationship	Receiving Services? (payor, waiver, etc.)	Age
<b>Primary Care Giver</b> (non-paid care)			
Time spent providing care per day    _____ Hours    _____ Minutes			
_____			
Home Environment (Can home accommodate plan of care?)			
_____			
<b>Other Waivers In Home</b> (ODMR/DD, ODA, what service?)			
_____			
<b>Other Services Present In Home At Time Of PDN Assessment</b> (meals, health aid, respite, etc)			
_____			
_____			
_____			
_____			
_____			
_____			

Name \_\_\_\_\_

<b>LEVEL OF CARE</b>	
<b>Check all boxes that apply to the consumer</b>	
<input type="checkbox"/>	Requires hands-on assistance with at least two activities of daily living.
<input type="checkbox"/>	Requires hands-on assistance with one activity of daily living, needs medication and is unable to self-administer those medications.
<input type="checkbox"/>	Requires awake supervision on a 24-hour basis to prevent harm due to cognitive impairment.
<input type="checkbox"/>	Is below age five and exhibits at least three developmental delays in the following areas: (adaptive behavior; physical development; sensory development; communication; cognition; social or emotional development) and would benefit from services to promote acquisition of skills and to decrease or prevent regression.
<input type="checkbox"/>	Is age six through 15 with at least one other diagnosed condition, other than mental illness, the condition manifested before the consumer's 22nd birthday and is likely to continue indefinitely, has functional limitations in three or more major life areas (capacity for independent living, communication, learning, mobility, personal care and self-direction), and would benefit from services that promote acquisition of skills and prevent or decrease regression in the performance of tasks in the major life areas.
<input type="checkbox"/>	Needs at least one skilled nursing service and/or PT, OT or speech pathology at less than a skilled level of care threshold .
<input type="checkbox"/>	The consumer has a need for at least one skilled nursing service to be delivered 7 days a week (7 distinct visits on 7 distinct days) and/or PT, OT or speech pathology to be delivered at least 5 days a week (5 distinct visits on 5 distinct days), <u>as</u> ordered by a physician and delivered by a licensed and/or certified professional due to either:  _____ The instability of the individual's condition, meaning the documentation reflects the individual's condition changes frequently and rapidly requiring constant monitoring and/or frequent adjustment to the treatment regime (at least monthly), and the complexity of the prescribed service; <b>or</b>  _____ The instability of the individual's condition, meaning the documentation reflects the individual's condition changes frequently and rapidly requiring constant monitoring and/or frequent adjustment to the treatment regime (at least monthly), and the presence of special medical complications.
<input type="checkbox"/>	<b>The consumer does <u>not</u> have a level of care comparable to an institutional level of care and therefore does not meet eligibility requirements for Private Duty Nursing.</b>
<input type="checkbox"/>	<b>The consumer has a level of care comparable to an institutional level of care.</b>

Name \_\_\_\_\_

<b>DIAGNOSIS</b>
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<b>MEDICAL HISTORY</b>			
	Name	Phone	Fax
Primary Care Physician			
Pulmonologist			
Cardiologist			
Neurologist			
Neurosurgeon			
ENT			
Gastroenterologist			
Endocrinologist			
Psychiatrist			
Geneticist			
General Surgeon			
Orthopedist			
Ophthalmologist			
Other			

<b>HOSPITAL HISTORY</b>					
Hospitalization		ER Visits		Surgeries	
Date	Reason	Date	Reason	Date	Reason

<b>THERAPY</b>		
ST Frequency	PT Frequency	OT Frequency
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>





Name \_\_\_\_\_

<b>CARDIAC</b>		
Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	SOB <input type="checkbox"/> Yes <input type="checkbox"/> No	Edema <input type="checkbox"/> Yes <input type="checkbox"/> No
Cyanosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Cap Refill	
Notes _____ _____		
<b>NUTRITION</b>		
Weight	Height	Recent Wt Loss/Gain
Birth Wt (if under 1 year)		Premature (weeks gestation)
Failure to Thrive <input type="checkbox"/>	Dietician	How Often
Diet Type	Feeding Type <input type="checkbox"/> PO <input type="checkbox"/> GT <input type="checkbox"/> NG <input type="checkbox"/> JT	
Bolus <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency	
Pump <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency	
<input type="checkbox"/> Uncomplicated <input type="checkbox"/> Complicated		
Feeding Supplies		
Stoma Care		
Notes _____ _____		
<b>SKIN INTEGRITY</b>		
Parental Access <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe	
Decubitus Ulcers (enter the number)	<input type="checkbox"/> Stage 1	<input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4
Venous Stasis Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe	
Surgical Wounds <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe	
Other types <input type="checkbox"/> Abrasions <input type="checkbox"/> Skin Tear <input type="checkbox"/> Lacerations <input type="checkbox"/> Other		
Turning Schedule	<input type="checkbox"/> Wound Vac	Supplier
Pressure relieving devices		
Other preventive treatments		
<b>Skincare Interventions</b>		
Area	Treatment	Frequency
Notes/Concerns _____ _____ _____		

Name \_\_\_\_\_

<b>GI/GU</b>				
Incontinence Bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Incontinence Bowel	<input type="checkbox"/> Yes <input type="checkbox"/> No
Catheter Type			Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
PRN Cath Freq			Diarrhea (# episodes QD)	
HX UTI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel Program	<input type="checkbox"/> Yes <input type="checkbox"/> No
I/O	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Laxative Usage	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colostomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ileostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Notes _____				
<b>NEUROLOGICAL</b>				
<input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Agitated/Aggressive				
Present Behavior			Unable to follow directions <input type="checkbox"/>	
MRDD	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Profound
Seizure Types Current Past			Diastat Rx <input type="checkbox"/> Yes <input type="checkbox"/> No Last Used	
Vagal Nerve Stimulator <input type="checkbox"/> Yes <input type="checkbox"/> No				
Number of Seizures _____			<input type="checkbox"/> QD <input type="checkbox"/> WK <input type="checkbox"/> MONTH	
Average duration of seizures _____				
<b>Unusual Circumstances/Precautions</b>				
Notes _____				
Visual Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Glasses Last eye exam				
Cataracts <input type="checkbox"/> R <input type="checkbox"/> L		Blind <input type="checkbox"/> R <input type="checkbox"/> L legally		Glaucoma <input type="checkbox"/> R <input type="checkbox"/> L
Hearing Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No Exam Date				
Deaf <input type="checkbox"/> R <input type="checkbox"/> L		Sign Language <input type="checkbox"/>		Hearing Aids <input type="checkbox"/> R <input type="checkbox"/> L wears them <input type="checkbox"/>
Verbal <input type="checkbox"/> Yes <input type="checkbox"/> No		Non-Verbal <input type="checkbox"/> Yes <input type="checkbox"/> No		Age appropriate <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Behaviors</b>				
	Frequency	Duration	Triggers	Intervention
Hitting				
Biting				
Screaming				
Aggressive				
Kicking				
Loner				
Fearful				
Other				
Other				

