HCH, Inc. / CONNECT Project

NURSING ASSESSMENT FORM

Date: _____

Address Client Assessed: _____ Balto., MD 212 Phone: _____
Street Address / Apt. No. Zip

DOB: _____ SSN: _____ ER Contact: _____

Referring Agency; _____ Contact: _____

Reason for Referral: _____

Primary Care Provider: _____ PCP's Phone; _____

Past Medical History: _____

HIV History: CD4 _____ (Date) VL _____ (Date) Ols: _____

Current HAART Meds: _____

Any Current Problems/Side Effects on HAART? No_ Y e s If yes, describe: _____

Past HAART Meds: _____

Reason for stopping HAART Meds: _____

Past Hospitalizations (Starting with most recent): _____

Teaching Needs: _____

Treatment Plan: _____

CLIENT LAST NAME: _____ FIRST: _____ HCH#: _____

PHYSICAN EXAMINATION

ROS:
NEURO:
CV:
Resp.:
GI:
GU:
EENT:
Skin:

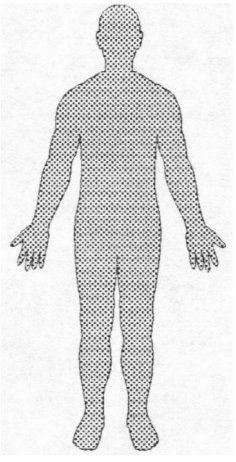
NOTES:

Skin: ☐ intact ☐ Red ☐ Compromised

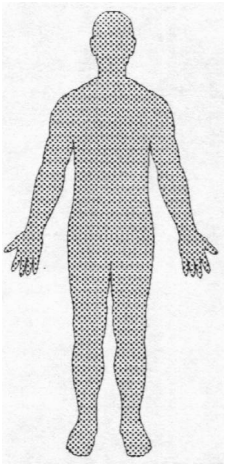
(described below)

Indicate Location and Shape of Skin Abnormalities of Figure **Below:**

Front



Back



Extremites: ☐ Moves All Well

☐ Strength Equal

☐ Wounds/Deformity

Describe: _____

El Pulse:

☐ Color:

☐ Capillary Refill: ☐ > 2 seconds

☐ < 2 seconds