Required Form

NURSE ASSESSMENT

Check appropriate box: ☐ Initial ☐ Reassessment

VITALS

Height ____________ Baseline Weight *(at time of initial diagnosis)* ___________ Current Weight ___________

CD4 count ________ Date ____________________ Lowest CD4 __________ Date ___________

Viral Load ___________ Date ___________ Highest Viral Load _______________ Date ___________

HIV STATUS

☐ NO CHANGE

☐ HIV - positive (not AIDS)/ date of diagnosis _______________________________

☐ HIV - positive (AIDS status unknown)/ date of diagnosis _______________________________

☐ CDC - defined AIDS/ date of diagnosis _______________________________

MEDICAL CARE

☐ NO CHANGE ☐ ISSUE RESOLVED

Is client currently receiving medical care? ☐ Yes ☐ No

If yes, what is the source of primary HIV medical care?

- ☐ Publicly - Funded Clinic or Health Department
- ☐ Private Practice
- ☐ Hospital Outpatient Center
- ☐ Emergency Room
- ☐ No Primary Source of Care
- ☐ Other ____

Providers Contact Information

Prmary Care Provider ____ (_____) __________________

HIV/AIDS Provider ____ (_____) __________________

Pharmacy ____ (_____) __________________

Dentist ____ (_____) __________________

ACTIVITIES OF DAILY LIVING (ADL)

☐ NO CHANGE ☐ ISSUE RESOLVED

ACTIVITY	SELF	NEEDS ASSIST.	DEPENDENT		ACTIVITY	SELF	NEEDS ASSIST.	DEPENDENT
Ambulation					Laundry			
Bathing					Meal Prep.			
Dressing/ Grooming					Shopping			
Driving					Toileting			
Eating					Transfers			
Housekeeping								

Client Name ________________________ Client # _______________ CM Initial __________ Date __________

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GENERAL HISTORY:

☐ NO CHANGE ☐ ISSUE RESOLVED

Current symptions/complaints:

☐ Abdominal Pain* ______	☐ Swollen lymph glands ______
☐ Change in eating habits* ______	☐ Seizures or Tremors ______
☐ Nausea/vomiting* ______	☐ Balance changes/falls ______
☐ Diarrhea* ______	☐ Dizziness ______
☐ Wasting/weight loss* ______	☐ Strength changes ______
☐ Difficulty swallowing* ______	☐ Numbness ______
☐ Sore throat or mouth* ______	☐ Pain ______
☐ Hearing changes ______	☐ Chest pain ______
☐ Headache, describe: ______	☐ Cough ______
☐ Fever ______	☐ Shortness of breath ______
☐ Chills ______	☐ Skin changes/rashes ______
☐ Fatigue ______	☐ Vision changes ______
☐ Night Sweats ______	☐ Other ______

***NUTRITIONAL ASSESSMENT (Page 8) Required.**

ALLERGIES

☐ NO CHANGE ☐ ISSUE RESOLVED

Does client suffer from any allergies? ☐ Yes ☐ No

IF YES, PLEASE INCLUDE SYMPTOMS:

______

______

Medication/drug	☐ Yes	☐ No	Which? ______
Food	☐ Yes	☐ No	Which? ______
Environmental	☐ Yes	☐ No	Which? ______

Client Name ______ Client # ______ CM Initial ______ Date ______

MEDICATION PROFILE

☐ **NO CHANGE**

Date	Medication	Dose	Freq	Route	Date / /	Date / /	Date / /	Date / /	Date / /

Medications Administered By: ____________________

Legend: **C** = Medication continues w/o changes **Dc'd** = Medication discontinued

What complementary therapies does the client use? ____________________

____

Is the medical provider aware of complementary therapies? ☐ Yes ☐ No

History of elevated LIPIDS (Cholesterol/Triglyceride) ☐ Yes ☐ No

Client Name ____________ Client # ____________ CM Initial ________ Date ________

☐ N/A ☐ NO CHANGE ☐ ISSUE RESOLVED

HIV MEDICATION ADHERENCE ASSESSMENT *(check appropriate responses)*

Is Client currently taking meds?		
☐ **Yes**	☐ **Sometimes**	☐ **No**
☐ Manages own meds ☐ Reports missed doses Further intervention needed? ☐ Yes ☐ No	☐ Taking HIV meds but having problems Further intervention needed? ☐ Yes ☐ No	☐ Wants to start meds ☐ Not recommended by provider at this time ☐ Thinking about starting meds ☐ Does not want to take HIV meds

Client understanding of medication:

☐ thorough ☐ average ☐ basic ☐ confused

Are medicines properly stored? ☐ Yes ☐ No

Are bottles in childproof containers? ☐ Yes ☐ No

Are bottles easy to open? ☐ Yes ☐ No

Are meds outdated? ☐ Yes ☐ No

Prescribed by multiple physicians? ☐ Yes ☐ No

Is a visual dosage chart used? ☐ Yes ☐ No

Has client ever “borrowed” medicines from another person? ☐ Yes ☐ No

If yes, how many times? ____________________

Who is responsible for ordering refills? ☐ Self and/or ____________________

Who picks up refills? ☐ Self and/or ____________________

Prescriptions refilled by: ☐ Pharmacy ☐ Mail ☐ Physician

Comments

CLIENT DAILY LIVING

Are meds taken on schedule every day/every time? ☐ Yes ☐ No

Number of doses taken late in last week? ______________________________

Has client missed a dose? ☐ Yes ☐ No If so, how many times in the past week? ____________

Why? ____

Eating Habits: ☐ B ☐ L ☐ D ☐ Snacks Is water taken with meds? ☐ Yes ☐ No ☐ Other

Is client a MORNING, AFTERNOON or NIGHTOWL person? ☐ am ☐ pm ☐ Nightowl

Is medical provider aware of adherence problems? ☐ Yes ☐ No

Further intervention needed? ☐ Yes ☐ No

Comments

Client Name ______________________ Client # ______________ CM Initial __________ Date __________

MEDICATION SIDE EFFECTS

☐ **N/A** ☐ **NO CHANGE** ☐ **ISSUE RESOLVED**

Is client having any side effects from taking the medications? ☐ Yes ☐ No If yes, continue --

☐ Dizziness ☐ Nausea ☐ Rash ☐ Diarrhea ☐ Drowsiness ☐ Headache ☐ Other ____________

Contraindications ____

Medical provider notified? Date ____________ Time ____________

Pharmacy contacted? Date ____________ Time ____________

BARRIERS TO HIV MEDICATION ADHERENCE *(Check all that apply)*

☐ **NO CHANGE**

☐ Depression/mental health
☐ Works outside the home
☐ Alcohol and drug use/abuse
☐ Complex medication regimen
☐ Care giving responsibilities
☐ Difficulty getting refills
☐ Lack of regular schedule
☐ Taste of medication
☐ Number of pills
☐ Undisclosed HIV status
☐ Side effects
☐ Lack of information
☐ Mental status changes
☐ Lack of social support
☐ Doubts medication effectiveness
☐ Needs assistance with ADLs
☐ Size of pills
☐ Eating habits

ADHERENCE PLAN:

Client Name ____________________ Client # ______________ CM Initial __________ Date __________

ORAL HEALTH

☐ N/A ☐ NO CHANGE ☐ ISSUE RESOLVED

☐ Has seen dentist in past six (6) months. Date ______________________________

☐ Client reports practicing daily oral hygiene.

☐ Client has dentures.

- ☐ Need adjustment.

☐ Client reports oral health problems.

- ☐ Reports episodic pain and/or sensitivity in teeth, gums or mouth.
- ☐ Missing days from work because of problems with teeth, gums or mouth.
- ☐ Client reports difficulty interacting with others because oral health problems negatively impact self-esteem.
- ☐ Difficulty eating.
- ☐ Client has difficulty talking because of oral health problems.

☐ Visual exam performed.

- ☐ Few or missing teeth.
- ☐ Observed appearance of dark, discolored teeth; missing teeth; bleeding, red gums; other problems with mouth.
- ☐ Observed appearance or client report of decayed teeth; white, hairy growth or creamy, bump-like patches; oral lesions or bleeding from gums/teeth.

Comments:

Client Name ______________________ Client # ______________ CM Initial _________ Date _________

NUTRITIONAL ASSESSMENT: ☐ N/A ☐ NO CHANGE ☐ ISSUE RESOLVED

Current weight ______________ Ideal weight ______________

☐ Assess Access to food; Is client getting enough to eat? ☐ Yes ☐ No

☐ Visual assessment of client's physical appearance, ie. signs of wasting syndrome, significant weight loss, or other obvious physical maladies. (Is weight loss significant based on period of time of weight loss, how much weight was lost, build of client, possible causes for weight loss, client's appetite):

____

____

____

____

☐ Assess abdominal pain issues (any problems, diagnosis, and/or treatment regimen):

____

____

☐ Change in eating habits (eating less, more, can't eat specific foods, allergies to foods, what meals eaten, types of food eaten, any nutritional supplements with amount and frequency, difficulty chewing or swallowing and why): ____

____

☐ Assess for nausea, vomiting and diarrhea (frequency, if possible, what is causing condition, if acute or chronic): ____

____

☐ If Nutritional Health is affected by Oral Health, see Oral Health Assessment Section (Page 7).

☐ Further intervention needed? ☐ Yes ☐ No

Possible Interventions:

1. Nutritional plan including vitamines, minerals and regular wieght checks.
2. Nutritional assessment with a registered dietician.
3. Referral to dental care.
4. Referral to a denturist to assess dentures.
5. Referral to primary care or HIV care.
6. Referral to counseling if an eating disorder, depression or other mental health concern is a possible issure.
7. Nutritional Incentive Contract, if appropriate.

NUTRITIONAL PLAN:

Client Name ______________________ Client # ______________ CM Initial __________ Date __________

MEDICAL HISTORY:

☐ N/A ☐ NO CHANGE ☐ ISSUE RESOLVED

Does the client now, or has the client ever had any of the following:

Opportunistic Infection	Date	Opportunistic Infection	Date
☐ ADC (AIDS Dementia Complex)		☐ Lymphoma	
☐ Candidiasis (Esophageal, Oral, Vaginal)		☐ Mycobacterium Avium Complex (MAC)	
☐ Cervical Cancer		☐ Myopathy	
☐ Cholesterol (Elevated)		☐ Oral Hairy Leukoplakia	
☐ Chronic/recurrent Sinusitis		☐ Parasitic Infection	
☐ CMV (Cytomegalovirus)		☐ Pneumoncystis Carinii Pneumonia (PCP)	
☐ Coccidioidomycosis		☐ Pneumonia (Bacterial)	
☐ Cryptococcal Meningitis		☐ Progressive Multifocal (PML)	
☐ Crytosporidiosis		☐ Sexually Transmitted Disease	
☐ Diabetes		Which one(s)?	
☐ Encephalopathy			
☐ Herpes Simplex		☐ Thrombocytopenia	
☐ Herpes Zoster		☐ Toxoplasmosis (Toxo)	
☐ Hep A, B, C		☐ Tuberculosis	
☐ Histoplasmosis		☐ Other (Specify)	
☐ Kaposi's Sarcoma			
☐ Leukoen Cephalopathy			

Tests and Treatments	Date	Results
Chemotherapy ☐ Yes ☐ No		
Infusion ☐ Yes ☐ No		
Radiation ☐ Yes ☐ No		
☐ Hepatitis C test		
☐ Treated ☐ Completed Course		
☐ PPD test →		mm
Dx of Latent TB ☐ Yes ☐ No Treatment Completed? ☐ Yes ☐ No When __________ Where __________ Dx of Active TB ☐ Yes ☐ No Where in body? __________ Where treatment received?__________ Dates of treatment: __________		
☐ RPR blood test for Syphilis		
☐ Gonorrhea Test		
☐ Chlamydia Test		

Client Name ________________ Client # __________ CM Initial _______ Date ______

MEDICAL HISTORY: *(Continued)*

Immunizations	Date
☐ Hepatitis A (HAV)	
☐ Hepatitis B (HBV)	
☐ Influenza	
☐ Measles, Mumps and Rubella (MMR)	
☐ Polysaccharide Pneumococcal	
☐ Tetanus and Diphtheria Toxoid (Td)	
☐ Tetanus, Diphtheria and Pertussis (Tdap)	
☐ Other *(Specify)*	

HIV Risk Factors *(check all that apply)*		
☐ MSM	☐ Heterosexual	☐ Receipt of transfusion of blood, blood components or tissue
☐ IDU	☐ Perinatal	☐ Other *(Specify)*
☐ Hemophilic Coagulation Disorder	☐ Undetermined/Unknown/Risk/ not reported or identified	

Sexually Transmitted Diseases

Does the client currently have any of these symptoms? *(Check all that apply)*

☐ Genital ulcers, warts, blisters or other lesions ☐ Pain with sex
☐ Pain or burning with urination ☐ Oral lesions
☐ Pain in the lower abdomen ☐ New or unusual skin rash

For men: ☐ Urethral discharge ☐ Testicular or groin pain

For women: ☐ Increased bloody foul-smelling vaginal discharge
☐ Vulvar itching ☐ Changes in periods ☐ Bleeding between periods

Has the client ever been told by a doctor or nurse that they had a sexually transmitted infection?
☐ Yes ☐ No ☐ Unsure *If yes, check all that apply:*

Infection	Date	Infection	Date
☐ Herpes Simplex		☐ Trichomonasomavirus	
☐ Chlamydia		☐ Lymphogranuloma Verereum (LGV)	
☐ Gonorrhea		☐ Pelvic Inflammatory Disease	
☐ Syphilis		☐ HPV	

GYNECOLOGICAL (Women only) ☐ N/A ☐ NO CHANGE ☐ ISSUE RESOLVED

☐ Vaginal discharge ☐ Vaginal itching/burning Currently pregnant ☐ Yes ☐ No
No. of pregnancies __________ No. of live births _________ Currently breastfeeding ☐ Yes ☐ No
☐ Birth control use (type ________________________________) Date of last breast exam _____________
Last menstrual period __________________ Hx of abnormal menstrual bleeding? ☐ Yes ☐ No
Hx of abnormal PAP smear? ☐ Yes ☐ No Date of last PAP ___________________
Result of last PAP ____

Nurse Signature & Credentials: ____

Client Name ________________________ Client # _______________ CM Initial __________ Date __________

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ADDITIONAL COMMENTS / NURSING PLAN:

Nurse Signature & Credentials: ______________________________

Client Name ____________________ Client # ______________ CM Initial __________ Date __________