RDN assessment

Please complete the survey below.

Thank you!

NUTRITION ASSESSMENT

Date	_____
First and last name	_____
Is client willing to participate in services?	◯ Yes ◯ No
Height (inches)	_____
Weight (lbs)	_____
Has client experienced unintentional weight loss	◯ yes ◯ no ◯ unsure
If so, total weight loss (lbs)	_____
Time frame of weight loss (months)	_____
Assessment note - Please address the following: Health conditions Health mgmt (lab values, glucose meter, BP cuff) Foods eaten besides MOW How food is accessed or secured Medications Help from caregivers Other relevant information	_____

Intervention(s) provided

- ☐ Assisted with MOW selections
- ☐ Reviewed recommended carb intake/day
- ☐ Reviewed recommended sodium intake/day
- ☐ Reviewed importance of monitoring blood sugar
- ☐ Reviewed importance of monitoring blood pressure
- ☐ Reviewed frequency of attending primary care appointments
- ☐ Suggested options for acquiring blood glucose monitoring device
- ☐ Suggested options for acquiring blood pressure monitoring device
- ☐ Recommended meals to be eaten besides MOWs
- ☐ Recommended snacks to be eaten
- ☐ Reviewed sugar-sweetened beverages consumed throughout the day
- ☐ Reviewed consumption of balanced, high-variety meals
- ☐ Reviewed high vs low sodium foods
- ☐ Reviewed high vs low carb foods
- ☐ Reviewed high vs low protein foods
- ☐ Reviewed high vs low potassium foods
- ☐ Reviewed high vs low phosphorus foods
- ☐ Reviewed high vs low fat foods
- ☐ Reviewed modified texture diet
- ☐ Reviewed fluid restrictions
- ☐ Recommended referral to speech-language pathologist
- ☐ Reviewed medication adherence
- ☐ Reviewed risk or presence of unintentional weight loss
- ☐ Reviewed weight management strategies
- ☐ Reviewed simple meal preparation strategies

RDN approved frozen meals

Please complete the survey below.

Thank you!

63) Name _____

64) Date _____

Frozen Meal Choices

65) Breakfast Choices

- ☐ Waffle & Sausage (D) (H)
- ☐ Cheese Omelet (D) (H)
- ☐ Pork Sausage Breakfast Bowl (D)
- ☐ Sausage & Egg Sandwich (D) (H)
- ☐ Biscuits & Sausage Gravy
- ☐ Breakfast Skillet (D)
- ☐ Blueberry Pancakes (D) (H)
- ☐ French Toast Sticks (H)
- ☐ Smothered Omelet (D) (H)

66) Beef Choices

- ☐ Meatloaf w/ Gravy (H)
- ☐ Salisbury Steak w/ Gravy (H)
- ☐ Hamburger
- ☐ Beef Stew
- ☐ Country Fried Steak
- ☐ Burger Parmesan (H)

67) Chicken Choices

- ☐ Chicken Cordon Bleu
- ☐ Grilled Chicken Breast (D) (H)
- ☐ Santa Fe Chicken (D)
- ☐ Chicken Rice Casserole (H)
- ☐ Chicken & Broccoli Ch. Casserole (D)
- ☐ Chicken Nuggets (D) (H)
- ☐ Chicken Pasta Parmesan
- ☐ Popcorn Chicken Bowl
- ☐ Chicken Mornay (H)
- ☐ Chicken Tikka Masala (H)
- ☐ Sweet & Sour Chicken (D) (H)
- ☐ Chicken & Dumplings (H)
- ☐ BBQ Chicken (H)
- ☐ Spaghetti & Turkey Meatballs

68) Pork Choices

- ☐ Italian Sausage with Peppers
- ☐ BBQ Pork Riblet
- ☐ Country-Fried Pork (D)
- ☐ Kielbasa w/ Sauerkraut (D)

69) Seafood Choices

- ☐ Potato-Breaded Pollock (D) (H)
- ☐ Fish Marinara (D)

70) Vegetarian Choices

- ☐ Cheese Tortellini w/ Marinara Sauce (D)
- ☐ Cornbread & Chili
- ☐ Cheese Stuffed Shells (D) (H)
- ☐ Macaroni & Cheese (D) (H)
- ☐ Cheddar Pierogis

RDN follow-up

Please complete the survey below.

Thank you!

Date	_____
First and last name	_____
Is client willing to participate in services?	◯ Yes ◯ No
Weight (lbs)	_____
Has client experienced unintentional weight loss	◯ yes ◯ no ◯ unsure
If so, total weight loss (lbs)	_____
Time frame of weight loss (months)	_____

Follow-up interventions provided	☐ Assisted with MOW selections ☐ Reviewed recommended carb intake/day ☐ Reviewed recommended sodium intake/day ☐ Reviewed importance of monitoring blood sugar ☐ Reviewed importance of monitoring blood pressure ☐ Reviewed frequency of attending primary care appointments ☐ Suggested options for acquiring blood glucose monitoring device ☐ Suggested options for acquiring blood pressure monitoring device ☐ Recommended meals to be eaten besides MOWs ☐ Recommended snacks to be eaten ☐ Reviewed sugar-sweetened beverages consumed throughout the day ☐ Reviewed consumption of balanced, high-variety meals ☐ Reviewed high vs low sodium foods ☐ Reviewed high vs low carb foods ☐ Reviewed high vs low protein foods ☐ Reviewed high vs low potassium foods ☐ Reviewed high vs low phosphorus foods ☐ Reviewed high vs low fat foods ☐ Reviewed modified texture diet ☐ Reviewed fluid restrictions ☐ Recommended referral to speech-language pathologist ☐ Reviewed medication adherence ☐ Reviewed risk or presence of unintentional weight loss ☐ Reviewed weight management strategies ☐ Reviewed simple meal preparation strategies
Comments, if applicable	_____

OT phone screening

Please complete the survey below.

Thank you!

Date

_____

LifeCare ID

_____

Name

_____

General history

Concerns of client

- ☐ Falls
- ☐ DME
- ☐ Mobility/function
- ☐ Fatigue/pain
- ☐ Exercise/physical activity
- ☐ Self-care
- ☐ Home Care Management

Height

_____

Weight

_____

Fall history

How many times have you fallen in the past year?

_____

How many days ago was your most recent fall?

_____

Do you use a mobility device?

- ◯ Yes
- ◯ No

Home environment

DME currently used

- ☐ N/A
- ☐ W/C
- ☐ RTS
- ☐ Rollator
- ☐ Walker
- ☐ Shower Chair
- ☐ Cane
- ☐ Grab bars

DME being requested	☐ N/A ☐ W/C ☐ RTS ☐ Rollator ☐ Walker ☐ Shower Chair ☐ Cane ☐ Grab bars
Do you have a tub shower or step-in shower?	◯ None of the above ◯ Tub shower ◯ Step-in shower
Do you rent or own?	◯ Rent ◯ Own
Do you live in a house or an apartment?	◯ House ◯ Apartment (complex) ◯ Mobile home ◯ Condo ◯ Townhome ◯ Other
How many bathrooms do you have?	_____
Where is your full bathroom located?	◯ First floor ◯ Second floor ◯ Basement

OT assessment

Please complete the survey below.

Thank you!

ASSESSMENT

96) Date

_____

97) Name

_____

General history

98) Vision

- ☐ WFL
- ☐ Glasses
- ☐ Min/mod Impairment
- ☐ Legally Blind
- ☐ Depth Perception
- ☐ Neglect
- ☐ Tracking
- ☐ Double Vision
- ☐ Uncorrected Cataracts

99) Hearing

- ☐ WFL
- ☐ Hearing Aids
- ☐ Mild/Moderate/Severe HOH

100) Cognitive impairments

- ☐ WFL
- ☐ Orientation
- ☐ Memory STM/LTM
- ☐ Attention
- ☐ Safety Awareness
- ☐ Problem Solving
- ☐ Following Directions
- ☐ Impulsivity

101) Pain scale (0-10)

_____

102) R grip average

_____

103) L grip average

_____

104) UE AROM

- ◯ WFL
- ◯ Impaired

105) Other UE Issues

- ☐ Edema
- ☐ Tremors
- ☐ Pain
- ☐ Fine motor impairment
- ☐ Sensory impairment

106) LE AROM
- ◯ WFL
- ◯ Impaired

107) Other LE Issues
- ☐ Edema
- ☐ Pain
- ☐ Sensory impairment
- ☐ Unable/able to bear weight
- ☐ Atypical Gait Pattern

108) Transfer Impairments
- ☐ To/from toilet
- ☐ To/from tub or shower
- ☐ To/from bed

109) Stairs/Steps Function
- ☐ Requires handrail
- ☐ Assistance required
- ☐ Independent
- ☐ N/A in client home/daily routine

110) Ambulation in home
- ◯ Able
- ◯ Unable
- ◯ Requires device

111) Ambulation in community
- ◯ Able
- ◯ Unable
- ◯ Requires device

112) Areas impacting optimal nutritional intake
- ☐ Functional Mobility
- ☐ Endurance
- ☐ Weakness
- ☐ Balance
- ☐ Pain
- ☐ UE function
- ☐ Cognition
- ☐ Environmental barriers
- ☐ Vision
- ☐ Transportation

113) Formal home exercise or physical activity
- ◯ Regular
- ◯ Occasional
- ◯ Previously but not currently
- ◯ None

Fall History

114) No. in last 3 months
- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5 or more

115) Injuries
- ◯ Yes
- ◯ No

116) TUG Score
- ◯ WNL
- ◯ Impaired

117) 30 Second Chair Stand Score

◯ WNL
◯ Impaired

Home Environment

118) Durable Medical Equipment (DME) in the home

☐ N/A
☐ W/C
☐ Rollataor
☐ Walker
☐ Cane
☐ Shower Chair
☐ Raised Toilet Seat (RTS)
☐ Grab bars
☐ Other

119) Noted Fall Hazards

☐ Clutter
☐ Handrail Issues
☐ Multiple Medications
☐ Rug Issues
☐ Inappropriate use of DME
☐ Pets
☐ Flooring Issues
☐ Lighting Issues
☐ Standing/Sitting Balance Impairment
☐ Holding on/Supporting self on household objects
☐ Other

120) If Other, then

_____

OT intervention

Please complete the survey below.

Thank you!

121) Name

_____

122) Date

_____

123) Intervention/Treatment provided

- ☐ Rollator provided
- ☐ Walker provided
- ☐ Manual w/c provided
- ☐ Transport w/c provided
- ☐ Quad cane provided
- ☐ Straight cane provided
- ☐ Knee scooter provided
- ☐ Shower seat provided
- ☐ Tub transfer bench provided
- ☐ Bedside commode provided
- ☐ Raised toilet seat provided
- ☐ Toilet safety frame provided
- ☐ Tub mount grab bar provided
- ☐ Reacher provided
- ☐ Hospital bed table provided
- ☐ Rearrangement of furniture
- ☐ Installation of rug tag
- ☐ Placement of contrast or tread tape
- ☐ Other intervention/treatment provided

124) Education and referrals

- ☐ Step repair
- ☐ Handrail repair or installation
- ☐ Throw rug removal or modification
- ☐ Door opening strategies
- ☐ Lighting improvements
- ☐ Environmental condition improvements
- ☐ Flooring improvements
- ☐ Space or pathway improvements
- ☐ Furniture modifications
- ☐ Footwear improvements
- ☐ Pet care strategies
- ☐ Medication management strategies
- ☐ Exercise program
- ☐ Energy conservation
- ☐ Task adaptation
- ☐ Emergency response system
- ☐ Mobility DME strategies
- ☐ Bathroom DME strategies
- ☐ Other DME strategies
- ☐ Home modification
- ☐ Referral to CHORES
- ☐ Referral to PCP
- ☐ Referral to FCSO
- ☐ Referral to VA
- ☐ Referral to HAH
- ☐ Referral to MOW
- ☐ Referral to Wellness
- ☐ Other recommendations and referrals

125) Caregiver education provided?

- ◯ Yes
- ◯ No

OT follow-up

Please complete the survey below.

Thank you!

126) Name

_____

127) Date

_____

128) Intervention/Treatment provided

- ☐ Rollator provided
- ☐ Walker provided
- ☐ Manual w/c provided
- ☐ Transport w/c provided
- ☐ Quad cane provided
- ☐ Straight cane provided
- ☐ Knee scooter provided
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- ☐ Installation of rug tag
- ☐ Placement of contrast or tread tape
- ☐ Other intervention/treatment provided

129) Education and referrals

- ☐ Step repair
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- ☐ Throw rug removal or modification
- ☐ Door opening strategies
- ☐ Lighting improvements
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- ☐ Referral to FCSO
- ☐ Referral to VA
- ☐ Referral to HAH
- ☐ Referral to MOW
- ☐ Referral to Wellness
- ☐ Other recommendations and referrals

130) Caregiver education provided?

- ◯ Yes
- ◯ No