RDN Assessment And Diagnosis

Please complete the survey below.

Thank you!

ASSESSMENT

Date ______________________

First and last name ______________________

Nutritional history

Height (inches) ______________________

Weight (lbs) ______________________

Has client experienced unintentional weight loss
- ◯ yes
- ◯ no
- ◯ unsure

If YES to above question, amount lost ______________________

Lost weight over how many months ______________________

Lab Values

Glucose (Fasting) ______________________

Glucose (Not Fasting) ______________________

AIC levels ______________________

Blood Pressure ______________________

Medications

Medications

____

Nutrition Diagnosis

Nutrition Diagnosis

- ☐ Excessive carbohydrate intake (NI-5.8.2)
- ☐ Inconsistent carbohydrate intake (NI-5.8.4)
- ☐ Excessive mineral (sodium) intake (NI-5.10.2)
- ☐ Other

If other, please explain

____

Etiology

____

Signs and symptoms

____

Nutrition education provided?

- ◯ Yes
- ◯ No

RDN Approved frozen meals

Please complete the survey below.

Thank you!

70) Name ______________________________

71) Date ______________________________

Frozen Meal Choices

72) 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)

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

74) 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

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

76) Seafood Choices
- ☐ Potato-Breaded Pollock (D) (H)
- ☐ Fish Marinara (D)

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

RDN Follow-up Note

Please complete the survey below.

Thank you!

Follow Up

78) Date ______________________

79) Blood sugar review
- ◯ yes
- ◯ no
- ◯ N/A

80) Blood pressure review
- ◯ yes
- ◯ no
- ◯ N/A

81) Do approved meals need changed?
- ◯ Yes
- ◯ No

82) Nutrition education provided?
- ◯ Yes
- ◯ No

RDN contact log

Please complete the survey below.

Thank you!

83) Date ______________________

84) Result of phone call
- ◯ Contact made; call complete
- ◯ Contact made; incomplete call
- ◯ No answer; no voicemail option/voicemail full
- ◯ No answer; left voicemail
- ◯ Left message with family/friend
- ◯ Disconnected or wrong number

85) Date ______________________

86) Result of phone call
- ◯ Contact made; call complete
- ◯ Contact made; incomplete call
- ◯ No answer; no voicemail option/voicemail full
- ◯ No answer; left voicemail
- ◯ Left message with family/friend
- ◯ Disconnected or wrong number

87) Date ______________________

88) Result of phone call
- ◯ Contact made; call complete
- ◯ Contact made; incomplete call
- ◯ No answer; no voicemail option/voicemail full
- ◯ No answer; left voicemail
- ◯ Left message with family/friend
- ◯ Disconnected or wrong number

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 and diagnosis

Please complete the survey below.

Thank you!

ASSESSMENT

105) Date

____

106) Name

____

General history

107) Vision

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

108) Hearing

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

109) Cognitive impairments

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

110) Pain scale (0-10)

____

111) R grip average

____

112) L grip average

____

113) UE AROM

- ◯ WFL
- ◯ Impaired

114) Other UE Issues

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

115) LE AROM

◯ WFL
◯ Impaired

116) Other LE Issues

☐ Edema
☐ Pain
☐ Sensory impairment
☐ Unable/able to bear weight
☐ Atypical Gait Pattern

117) Transfer Impairments

☐ To/from toilet
☐ To/from tub or shower
☐ To/from bed

118) Stairs/Steps Function

☐ Requires handrail
☐ Assistance required
☐ Independent
☐ N/A in client home/daily routine

119) Ambulation in home

◯ Able
◯ Unable
◯ Requires device

120) Ambulation in community

◯ Able
◯ Unable
◯ Requires device

121) Areas impacting optimal nutritional intake

☐ Functional Mobility
☐ Endurance
☐ Weakness
☐ Balance
☐ Pain
☐ UE function
☐ Cognition
☐ Environmental barriers
☐ Vision
☐ Transportation

122) Formal home exercise or physical activity

◯ Regular
◯ Occasional
◯ Previously but not currently
◯ None

Fall History

123) No. in last 3 months

◯ 0
◯ 1
◯ 2
◯ 3
◯ 4
◯ 5 or more

124) Injuries

◯ Yes
◯ No

125) TUG Score

◯ WNL
◯ Impaired

126) 30 Second Chair Stand Score

- ◯ WNL
- ◯ Impaired

Home Environment

127) Durable Medical Equipment (DME) in the home

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

128) 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

129) If Other, then

____

Fall risk diagnosis

130) Fall risk diagnosis

- ☐ Low fall risk
- ☐ Moderate fall risk
- ☐ High fall risk

131) Fall prevention education provided?

- ◯ Yes
- ◯ No

OT recommendations

Please complete the survey below.

Thank you!

---

132) Name

____

---

133) Date

____

---

134) General recommendations and referrals

- ☐ Follow physical activity/exercise program (provided)
- ☐ Use energy conservation techniques
- ☐ Contact CHORES department
- ☐ Contact primary care provider
- ☐ Contact FCSO
- ☐ Contact VA (if eligible)
- ☐ Contact HAH

---

135) Fall history recommendations

- ☐ Wear proper footwear
- ☐ Enable/Use an Emergency Response System
- ☐ Adapt daily tasks to reduce fall risk

---

136) Home environment recommendations

- ☐ Install/use of tub or shower seat
- ☐ Install/use of raised toilet seat
- ☐ Install/use of grab bar
- ☐ Use walker or cane
- ☐ Use wheelchair or transport chair
- ☐ Use adaptive equipment (e.g., reacher, bedrail)
- ☐ Remove/adapt rugs
- ☐ Remove clutter
- ☐ Ensure pathways are clear and accessible
- ☐ Ensure living spaces are well lit
- ☐ Ensure safe access to daily items

---

137) Caregiver education provided?

- ○ Yes
- ○ No

OT Followup Note - adherence

Please complete the survey below.

Thank you!

Follow up

138) Date

____

139) General recommendations and referrals reviewed

- ◯ Yes
- ◯ No
- ◯ N/A

140) How often is the participant adhering to general recommendations and referrals?

- ◯ None of the time
- ◯ Some of the time
- ◯ Most of the time
- ◯ All of the time
- ◯ N/A

141) Fall history recommendations reviewed

- ◯ Yes
- ◯ No
- ◯ N/A

142) How often is the participant adhering to fall history recommendations?

- ◯ None of the time
- ◯ Some of the time
- ◯ Most of the time
- ◯ All of the time
- ◯ N/A

143) Home environment recommendations reviewed

- ◯ Yes
- ◯ No
- ◯ N/A

144) How often is the participant adhering to home environment recommendations?

- ◯ None of the time
- ◯ Some of the time
- ◯ Most of the time
- ◯ All of the time
- ◯ N/A

OT contact log

Please complete the survey below.

Thank you!

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145) __________________________________

146) Result of phone call
- ◯ Contact made; call complete
- ◯ Contact made; incomplete call
- ◯ No answer; no voicemail option/voicemail full
- ◯ No answer; left voicemail
- ◯ Left message with family/friend
- ◯ Disconnected or wrong number

147) __________________________________

148) Result of phone call
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- ◯ Disconnected or wrong number

149) __________________________________

150) Result of phone call
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- ◯ Contact made; incomplete call
- ◯ No answer; no voicemail option/voicemail full
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- ◯ Left message with family/friend
- ◯ Disconnected or wrong number