Texas Department of Aging and Disability Services
Area Agency on Aging
AAA Consumer Needs Evaluation

Service Arrangement
C = Caregiver
P = Service will be purchased by AAA.
A = Other agency-non AAA vendor is providing the service.
N = Not applicable to this consumer.
S = Self

Consumer Name: ____________________

Consumer Number: ____________________

Assessment Date: ____________________

	Texas Score	NAPIS ADL/IADL	NAPIS Count	Scoring/Service Arrangement
I. Daily Living Impairment Assessment I. ADLs, IADL & Other*	ADL – Activity of Daily Living IADL - Independent Activity of Daily Living			* Impairment Scoring 0 = None 1 = Mild 2 = Severe 3 = Total Impairment
1. Do you have any problems taking a bath or shower?		ADL		
2. Can you dress yourself?		ADL		
3. Can you feed yourself?		ADL		
4. Can you groom yourself (shave, brush your teeth, shampoo and comb your hair)?				
5. Do you have problems getting to the bathroom and using the toilet?		ADL		
6. Do you have trouble cleaning yourself after using the bathroom?				
7. Can you get in and out of your bed or chair?		ADL		
8. Are you able to walk without help?		ADL		
9. Can you clean your house (sweep, dust, wash dishes, vacuum)?		IADL		
10. Can you do heavy housework (scrub floors, yard work, shovel snow, take out garbage)?		IADL		
11. Can you do your own laundry?				
12. Can you fix your meals?		IADL		
13. Can you do your own shopping?		IADL		
14. Can you take your own medicine?		IADL		
15. Can you trim your nails?				
16. Do you have any problems keeping your balance?				
17. Can you open jars, cans, bottles?				
18. Can you use the telephone?		IADL		
19. Are you able to perform transportation on your own?		IADL		
20. Do you have any trouble managing your money?		IADL		

Texas Department of Aging and Disability Services
Area Agency on Aging
AAA Consumer Needs Evaluation - Page 2

Consumer Name: ______________________________

Consumer Number: ______________________________

Assessment Date: ______________________________

Service Arrangement
C = Caregiver
P = Service will be purchased by AAA.
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N = Not applicable to this consumer.
S = Self

	Texas Score	NAPIS ADL/IADL	NAPIS Count	Scoring/Service Arrangement
II. Mental Health Screening				
21. During the last month, have you been bothered by having little interest or pleasure in doing things, or have you often felt down, depressed, or hopeless?				Scoring for question 21: 0 = If the answer is 'No' to question 21. 1 = If the answer is 'Yes' to 21 *and* 'No' to questions 22-25. 2 = If the answer is 'Yes' to 21 *and* 'Yes' to at least one of questions 22-25.. 3 = If the answer is 'Yes' to 21 *and* 'Yes to two or more of questions 22-25.
III. Mental Health Assessment – If the answer is YES to Question 21, continue. Otherwise, SKIP to Section IV.				
In the last two weeks, most of the day, nearly every day:				Based on Consumer's perception of self:
22. ... have you had problems sleeping?				Answer 'No' or 'Yes' for this question.
23. ... have you lost the ability to enjoy things that once were fun?				Answer 'No' or 'Yes' for this question.
24. ... do you feel that you have little value as a person?				Answer 'No' or 'Yes' for this question.
25. ... have you had a significant change in your appetite?				Answer 'No' or 'Yes' for this question.
Mental Health Assessment Score (II & III)				
IV. Cognition				
A. Self Evaluation				
26. During the last 2 weeks, on how many days have you had trouble concentrating or making decisions? (Based on Consumer's perception of self.)				0= Not at all. 1= Occasionally, a couple of times. 2= Frequently, more than a couple of times, but not every day. 3= Every day.
B. Third Party Observation				
27. Does the consumer have the ability to make decisions independently? (Based on someone's observation of the Consumer.)				0= Makes consistent and reasonable decisions independently. 1= Makes simple decisions without assistance. 2= Makes poor decisions, needs cues/supervision for most decisions. 3= Severely impaired, rarely makes own decisions.
28. Does the consumer appear to have short-term memory impairment? (Based on someone's observation of the Consumer.)				0= No 1= Has some short-term memory problems & can perform task for self with occasional reminders. 2= Has lapses resulting in frequently not performing task even with reminders. 3= Has memory lapses resulting in inability to perform routine tasks on a daily basis.

Texas Department of Aging and Disability Services
Area Agency on Aging
AAA Consumer Needs Evaluation - Page 3

Service Arrangement
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A = Other agency–non AAA vendor is priding the service.
N = Not applicable to this consumer.
S = Self

Consumer Name: ______________________________

Consumer Number: ______________________________

Assessment Date: ______________________________

	Texas Score	NAPIS ADL / IADL	NAPIS Count	Scoring / Service Arrangement
V. Assessment Scores				
A. Total CNE Impairment Score (out of 60) ☐ Low (Score 0-19) ☐ Moderate (Score 20-39)* ☐ Severe (Score 40 and above)				
B. NAPIS ADL COUNT (Score 0-6)				
C. NAPIS IADL COUNT (Score 0-8)				

* A score of 20 (moderate impairment) or greater is required for home-delivered meals.

______________________________ ______________
Signature of AAA/Provider Staff Assessor Date

SCORING THE CNE & NAPIS – ADL'S & IADL'S Rate the Consumer according to the following scale:

0	None	Able to conduct activities without difficulty and has no need for assistance.
1	Minimal/Mild	Able to conduct activities with minimal difficulty and needs minimal assistance.
2	Extensive/Severe	Has extreme difficulty carrying out activities of daily living and needs extensive assistance.
3	Total	Completely unable to carry out any part of the activity.

The AAA Consumer Needs Evaluation must be completed for the following services: Adult Day Care; Care Coordination (Care Management); Chore Maintenance; Home Delivered Meals; Homemaker; Personal Assistance; and Respite Care. Residential Repair requires service appropriate assessment, which may include the AAA Consumer Needs Evaluation.

The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Circle the number in the yes column for those that apply to you or someone you know. For each yes answer, score the number in the box. Total your nutritional score.

DETERMINE YOUR NUTRITIONAL HEALTH

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every dav.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's –

0-2 — **Good!** Recheck your nutritional score in 6 months.

3-5 — You **are at moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more — You **are at high nutritional risk.** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

These materials developed and distributed by the Nutrition Screening Initiative, a project of:

AMERICAN ACADEMY OF FAMILY PHYSICIANS

THE AMERICAN DIETETIC ASSOCIATION

NATIONAL COUNCIL ON THE AGING, INC.

Remember tbat warning signs suggest risk, but do not represent diagnosis of any condition. Turn tbe **page to learn more about tbe Warning Signs of poor nutritional bealth.**

The Nutrition Checklist is based on Warning Signs described below. Use the word **DETERMINE** to remind you of the Warning Signs.

DISEASE

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more of older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

EATING POORLY

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruit and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

TOOTH LOSS/ MOUTH PAIN

A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures which don't fit well or cause mouth sores make it hard to eat.

ECONOMIC HARDSHIP

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less--or choosing to spend less--than $2530 per week for food makes it very hard to get the foods you need to stay healthy.

REDUCED SOCIAL CONTACT

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

MULTIPLE MEDICINES

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

INVOLUNTARY WEIGHT LOSS/GAIN

Losing or gaming a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

NEEDS ASSISTANCE IN SELF CARE

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

ELDER YEARS ABOVE AGE 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

The Nutrition Screening Initiative, 2626 Pennsylvania Avenue, NW, Suite 301, Washington, DC 20037

© The Nutrition Screening Initiative is funded in part by a grant from Ross Laboratories, a division of Abbott Laboratories.

Meals On Wheels, Inc. of Tarrant County
Diabetes Acknowledgement and Risk Tool

(*Attachment C*)

Date:____________ Case Manager:___________________

Client Name:_________________________Zip Code:______

Does Client have a diagnosis of Diabetes? Yes:____ No:_____

If Yes is answered you may stop; If No is answered please complete the below Diabetes Risk Assessment. Please return this form to Director of Nutrition. Any clients at risk for diabetes should be given a completed form to show their medical provider.

DIABETES DETECTION INITIATIVE

DIABETES. YOU COULD BE AT RISK

TAKE THE TEST—KNOW YOUR SCORE!

Diabetes means your blood sugar (glucose) is too high. How would you know? Are you often thirsty, hungry, or tired? Do you urinate often? Do you have sores that heal slowly, tingling in your feet, or blurry eyesight? Even without these signs, you could still have diabetes.

Diabetes is a serious disease. It can cause heart attack or stroke, blindness, kidney failure, or loss of feet or legs. But diabetes can be controlled. You can reduce or avoid these health problems. Take the first step. Find out if you are at high risk.

Know your risk of having diabetes now. Answer these quick questions. For each Yes answer, add the number of points listed. All No answers are 0 points.

Question	Yes	No
Are you a woman who has had a baby weighing more than 9 pounds at birth?	1	0
Do you have a sister or brother with diabetes?	1	0
Do you have a parent with diabetes?	1	0
Find your height on the chart. Do you weigh as much as or more than the weight listed for your height? *(See chart on back)*	5	0
Are you under 65 years old and get little or no exercise in a typical day?	5	0
Are you between 45 and 64 years old?	5	0
Are you 65 years old or older?	9	0
Add Your Score		

These questions are from the American Diabetes Association's on-line "Diabetes Risk Test" (http://www.diabetes.org/info/risk/risktest.jsp).

Diabetes Detection Initiative
Finding the Undiagnosed

At Risk Weight Chart

Height	Weight (Pounds)	Height	Weight (Pounds)
4'10	129	5'8	177
4'11	133	5'9	182
5'0	138	5'10	188
5'1	143	5'11	193
5'2	147	6'0	199
5'3	152	6'1	204
5'4	157	6'2	210
5'5	162	6'3	216
5'6	167	6'4	221
5'7	172		

Know Your Score

If you scored . . .	then your risk is . . .
10 or more points	High for having diabetes now. **Please bring this form to your health care provider soon.** If you don't have insurance and can't afford a visit to your provider, contact your local health department.
3 to 9 points	Probably low for having diabetes now. Keep your risk low. If you're overweight, lose weight. Be active most days, and don't use tobacco. Eat low-fat meals with fruits, vegetables, and whole-grain foods. If you have high cholesterol or high blood pressure, talk to your health care provider about your risk for diabetes.

I Scored 10 or More

How Can I Get Tested for Diabetes?

If you have . . .	then do this . . .
Individual or group private health insurance	See your health care provider. If you don't have a provider, ask your insurance company about providers who take your insurance. Deductibles and co-pays will apply.
Medicaid	See your health care provider. If you don't have a provider, contact a state Medicaid office or contact your local health department.
Medicare	See your health care provider. Medicare will pay the cost if the provider has a reason for testing. If you don't have a provider, contact your local health department.
No insurance	Contact your local health department for more information about where you could be tested or call your local health clinic.

Steps to a HealthierUS

For more information, contact the Department of Health and Human Services, National Diabetes Education Program at 1-800-438-5383 or online at www.ndep.nih.gov.

[1]Health Questionnaire

(English version for the US)

[1] *© 1990 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group*

[2] *2008 NHIS Questionnaire - Family Family Health Status & Limitations* ***Document Version Date: 24-Apr-09***

[3] *Perceived Competence Scale, 2004, Williams et al.*

[1]By placing a checkmark in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

I have no problems in walking about	❑1
I have some problems in walking about	❑2
I am confined to bed	❑3

Self-Care

I have no problems with self-care	❑1
I have some problems washing or dressing myself	❑2
I am unable to wash or dress myself	❑3

Usual Activities *(e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities	❑1
I have some problems with performing my usual activities	❑2
I am unable to perform my usual activities	❑3

Pain/Discomfort

I have no pain or discomfort	❑1
I have moderate pain or discomfort	❑2
I have extreme pain or discomfort	❑3

Anxiety/Depression

I am not anxious or depressed	❑1
I am moderately anxious or depressed	❑2
I am extremely anxious or depressed	❑3

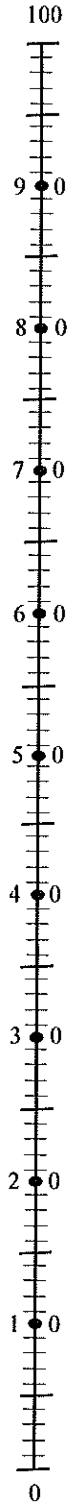
Total Score of Checked Boxes: ____________ / 15
The lower the score, the better the health

[2]**Would you say your health in general is**

Excellent	❑5
Very good	❑4
Good	❑3
Fair	❑2
Poor	❑1

Total: ____________ / 5
The higher the score, the better the health

[1] *© 1990 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group*
[2] *2008 NHIS Questionnaire - Family Health Status & Limitations* ***Document Version Date: 24-Apr-09***
[3] *Perceived Competence Scale, 2004, Williams et al.*
[4] *2011 NHIS Questionnaire—Family Access to Health Care & Utilization*



[2]To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

My Health State Today is:

____

[3]Perceived Competence Scale for Health

Help us better understand your needs. Please respond to each of the following items in terms of how true it is for you with respect to dealing with your health. Use the scale:

	1 not at all true	2	3	4 somewhat true	5	6	7 very true
I feel confident in my ability to manage my health.	o	o	o	o	o	o	o
I am capable of handling my health now.	o	o	o	o	o	o	o
I am able to do my own routine health care now.	o	o	o	o	o	o	o
I feel able to meet the challenge of controlling my health.	o	o	o	o	o	o	o

Total of Checked Boxes: __________ / 28
The higher the score, the greater the competence.

[1] *© 1990 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group*
[2] *2008 NHIS Questionnaire - Family Health Status & Limitations* ***Document Version Date: 24-Apr-09***
[3] *Perceived Competence Scale, 2004, Williams et al.*
[4] *2011 NHIS Questionnaire—Family Access to Health Care & Utilization*

[4]**2011 NHIS Questionnaire - Family Access to Health Care & Utilization**

1. Were you hospitalized OVERNIGHT in the past 6 months? (Do not include an overnight stay in the emergency room).

   ____

2. How many different times did you stay in any hospital overnight or longer DURING THE PAST 6 MONTHS?

   ____

3. Altogether, how many nights were you in the hospital DURING THE PAST 6 MONTHS? (Do not include ER).

   ____

4. During the last 6 months, did you see a doctor or other health care professional at a an emergency room? (Do not include times during an overnight hospital stay).

   ____

[1] *© 1990 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group*

[2] *2008 NHIS Questionnaire - Family Health Status & Limitations* ***Document Version Date: 24-Apr-09***

[3] *Perceived Competence Scale, 2004, Williams et al.*

[4] *2011 NHIS Questionnaire—Family Access to Health Care & Utilization*

Risk Factors for Hospitalization and Emergent Care Assessment

Name: ______________________________ Date: ________________

Prior Pattern *(check all that apply)*

☐ >1 Hospitalizations or ED visits in the past six months

☐ History of recent falls

Chronic Conditions *(check all that apply)*

☐ CHF

☐ Diabetes

☐ Chronic Skin Ulcers

☐ End Stage Renal Disease

☐ COPD/Asthma

☐ Advanced Liver Diseases

☐ HIV/AIDS

☐ Neoplasm as primary Diagnosis

☐ New Diagnosis /Problem

Risk Factors *(check all that apply)*

☐ 9 or more medications

☐ More than two secondary Diagnosis (M0240)

☐ Low Socioeconomic Status or Financial Concerns

☐ Lives Alone (M0340)

☐ Help with Managing Medications Needed

☐ Confusion *any* level (M0570)

☐ Short Life Expectancy (M0280)

☐ Poor Prognosis (M0260)

☐ Dyspnea *any* level (M0490, #1-4)

☐ Urinary Catheter (M0520)

☐ Open Wound (Stasis, Pressure, Diabetic ulcer, open surgical wound) (M0440)

Total of Checked Boxes: ________________
(6 or more indicates high risk for emergent care)

This material was prepared by Georgia QIO, the Medicare Quality Improvement Organization for Georgia under contract with the Centers for Medicare & Medicaid Services (CMS), and agency of the US Department of Health and Human Services. The contents do no reflect CMS Policy. Adapted by Deborah Chisholm, RN, BSN, CPHQ, COS-C from tools developed by: Personal Touch Home Care and At Home Care Richmond, VA. Based on: Rosati, R.J., Liping, H., Navale-Waliser, M., & Feldman, P.H. (2003) Risk Factors for Repeated Hospitalizations among Home Healthcare Recipients. Journal for Healthcare Quality, March/April 2003. Copyright permission to use this material is currently in process. If you are the original copyright holder of this material, please contact Laura Dugan at ldugan@vvmi.org.

Risk Factors for Hospitalization and Emergent Care Assessment
INSTRUCTIONS

	Description
Prior Pattern	
>1 Hospitalizations or ED visits in the past six months	More than one hospital or emergency department visit in the past six months
History of recent falls	Any falls in the past
Chronic Conditions	
CHF	Myocardial infarction or Ischemic Heart Disease
Diabetes	High blood sugar
Chronic Skin Ulcers	Long term sore on the skin
End Stage Renal Disease	Loss in renal function over a period of months or years
COPD/Asthma	Airway diseases causing difficulty to breathe
Advanced Liver Diseases	Any disease causing liver dysfunction
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Virus
Neoplasm as primary Diagnosis	Abnormal mass of tissue (benign or malignant)
New Diagnosis /Problem	Any New diagnosis not listed above
Risk Factors	
9 or more medications	If taking more than 9 medications
More than two secondary Diagnosis (M0240)	All conditions that coexisted at the time plan of care were established, or which developed subsequently, or affect the treatment of care.
Low Socioeconomic Status or Financial Concerns	Medicaid/Medicare/Uninsured
Lives Alone (M0340)	Identifies whomever the patient is living with at this time, even if the arrangement is temporary. (*Lives alone* does not include: With spouse or significant other, with other family member, with a friend, with paid help, with other than above)
Help with Managing Medications Needed	
Confusion *any* level (M0570)	Identifies the time of the day the patient is likely to be confused, if at all. (E.g. Never, In New or complex situations only; on awakening or at night only; during the day and evening, but not constantly; constantly; patient Nonresponsive)
Short Life Expectancy (M0280)	Identifies those patients for *whom life expectancy is fewer than six months.*
Poor Prognosis (M0260)	Identifies the patients' expected overall prognosis for recovery at the start of this home care episode (poor, good, fair/unknown)
Dyspnea *any* level (M0490, #1-4)	Identifies the patient's level of shortness of breath at *any* level (E.g., never; patient is short of breath when walking for more than 20 feet or climbing stairs; with moderate exertion like dressing or using commode or bedpan; with minimal exertion like while eating or performing other ADLs; or at rest)
Urinary Catheter (M0520)	Identifies presence of urinary or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology of incontinence is not addressed in this item.
Open Wound (Stasis, Pressure, Diabetic ulcer, open surgical wound) (M0440)	Identifies the presence of skin lesion or open wound. A lesion is a broad term used to describe an area of pathologically altered tissues. (Yes/No)

Meals On Wheels, Inc. of Tarrant County Intake Form

Client ID____________________

Original   Reintake   Update   Language spoken if not English ____________________

Date__________ From __________________ Rel__________ Ph__________ By______

Need & scheduling notes:____

____

____ Mapsco__________

☐ Cane ☐ Walker ☐ Wheelchair ☐ Dialysis ☐ Diabetic ☐ Stroke ☐ HBP ☐ CHF ☐ COPD ☐ Dementia

---

Name ____ Sex______
(Last) (First) (MI)

Address______________________________ Apt#______ Phone______________

City______________ Co. Tarrant State TX Zip________ DOB__________ Cell______________

Ethnicity:(1)Not Hispanic (2) Hispanic (3) Not Reported   Age:___ SSN:______________

Race: (1) White (Non Hispanic) (2) White (Hispanic) (3) American Indian/Alaska Native (4) Asian (5) Black or African American (6) Native Hawaiian or Other Pacific Islander (7) Persons Reporting Some Other Race (8) Race Not Rpt

Marital (1) Married (2) Widowed (3) Divorced (4) Separated (5) Never Married (6) Not Reported

Does client live alone Y N   Total in household______ Lives with______________________

Income: Household $__________ Client $__________ Head of Household M F H of H Age ____

Scores: Nutrition__________ CNE __________ Diabetes__________

Send letter yes no   Verified names & numbers on:

Primary Contact

Name______________________________

Address______________________________

City & Zip______________________________

Phone - H______________________________

Phone - W______________________________

Cell ______________________________

Rel.________________ Key?______

Name ______________________________

Phone H________________ W__________

Cell ______________________________

Rel.______________________ Key?______

Name______________________________

Phone H________________ W__________

Cell.______________________ Rel.______

Decision: Yes No Pull File: No Yes ________________ Monthly Recert: Yes No

Start ________________ Del. Days ______________ Cross Ref.______________

Meal: Reg Diet BK WK FZ Bev: C S LF JU EN+ GL Sup Only Rx Due______________

Site__________ Route__________ Placement:______________________________

Sp Instr____

____

Caseworker completing form:______________________________ Date______________

Funding source:______________________________

Rev 8/2011

Client:______________________________Date______________

Home Environment: Clean Dirty Cluttered Help Needed

Do you have safety bars or bath seat in tub? Yes No

Weight: Thin Normal Heavy Obese

Ambulates with: Cane Walker Prosthesis Wheelchair Bedfast

Primary Health Concern______________________________________

Additional Health Concerns: (Circle)

	Alzheimer's/ Dementia		Fibromialgia		Liver Disease		Seizure Disorder
	Amputee		Fracture________		Lungs:		Stomach Problems
	Arthritis		Hepatitis A B C		Asthma		Stroke
	Rheumatoid/ Osteo		Hearing Impaired		Emphysema		Thyroid problems
	Cancer ________		Heart:		COPD		Weakness
	Cerebral Palsy		Angina		Malnourished		Weight Loss
	Cholesterol		Arrhythmia		Mental Health		Other
	Confused / Forgetful		CHF		Depression/ Anxiety		
	Diabetes		Heart Attack		Bi Polar / Schizo		
	Edema		Hip/ Knee Replacement		Mental Retardation		
	Eye Problems:		HIV / AIDS		Multiple Scl.		
	Blind		Hypertension/ Hypotension		Neuropathy		
	Cataracts		Incontinent		Osteoporosis		
	Glaucoma		Kidney Disease		Paralysis		
	Mac. Deg.				Parkinson's		

Rx

	Abilify / aripiprazole		Hydrocodone		Plavix
	Actos / pioglitazone		Insulin		Prilosec / omeprazole
	Albuterol / proventil		Januvia / sitagliptin		Prozac / fluoxetine hcl
	Amaryl / glimepiride		Lexapro		Risperdal / risperdone
	Aricept / donepezil		Lipitor		Seroquel
	Atenolol		Lyrica		Synthroid / levothyroxine
	Buspar / buspirone		Metoprolol		Toprol / metoprolol succinate
	Coumadin / warfarin		Namenda		Valium / diazepam
	Cymbalta		Neurontin / gabapentin		Wellbutrin / bupropion hydrochloride
	DiaBeta / glyburide		Nexium / esomeprazole		Xanax / alprazolam
	Effexor		Norvasc / amloclipine besylate		Zestril / lisinopril
	Elavil / amitriptyline		Oxycontin / oxycodone		Zocor / simvastatin
	Glucophage / metformin				Zoloft / sertraline hcl
	Glucotro / glipizide				Zyprexa / olanzapine

Primary Care Physician:______________________________Phone______________

Hosp______________________________ Dr. FAX______________________

Need Pet Food Y N Who handles Finances?____________________

Dog # Large_______ # Small _______ Source of transportation?____________________

Cat____ Car? Y N

Medicare Medicaid Insurance Supplement Working smoke alarm? Y N

Client Name____________________ Date__________

Nutrition Ed discussed				

Nutrition Screening

I have an illness/condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different over-the-counter or prescribed drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
Total	

Current Agency Involvement:

Agency__________
Rep/Phone:__________
Service:__________

Agency:__________
Rep/Phone:__________
Service:__________

Referrals:

Agency__________
Date made__________
Phone/Rep__________
Service Requested__________
Outcome__________

Agency__________
Date made__________
Phone/Rep__________
Service Requested__________
Outcome__________

Referrals:

Agency__________
Date made__________
Phone/Rep__________
Service Requested__________
Outcome__________

Agency__________
Date made__________
Phone/Rep__________
Service Requested__________
Outcome__________