RNS: WellSky Intake Form

Client: _____ **Date of intake:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Contacts

Name and Relationship: _____ **POA?** ____

Phone Number (Home) (Cell): _____ **Email:** _____

Name and Relationship: _____ **POA?** ____

Phone Number (Home) (Cell): _____ **Email:** _____

Name and Relationship: _____ **POA?** ____

Phone Number (Home) (Cell): _____ **Email:** _____

Doctors, Pharmacy, Preferred Hospital, Medical Suppliers, etc.

Name: _____ **Specialty:** _____

Address: _____

Phone: _____ **Email:** _____

Name: _____ **Specialty:** _____

Address: _____

Phone: _____ **Email:** _____

Name: _____ **Specialty:** _____

Address: _____

Phone: _____ **Email:** _____

Name: _____ **Specialty:** _____

Address: _____

Phone: _____ **Email:** _____

Name: _____ **Specialty:** _____

Address: _____

Phone: _____ **Email:** _____

Care Goals:

Proposed Schedule: _____

Important Instruction for residence/facility:
Best way to access residence/facility: _____Code:_____
Specific parking area? _____
Front desk/bldg mgr/valet phone # _____
Housekeeper/secretary/assistant - Name: _____ Days:_____
Nanny cam/baby monitor/chair alarm/bed alarm:_____

Wi-Fi Instructions and Login: _____

Demographics:

Date of Birth: _____/_____/_____ Height: _____ Weight: _____ Gender: _____
Marital Status: _____ Lives with: (name and relationship) _____
DNR (Circle One): DNR, Full Code, or Unknown Past profession: _____

Medical Conditions: (any chronic/acute conditions, recent hospital/skilled nursing stays)

Hearing: ☐ Good ☐ Poor ☐ Deaf ☐ Hearing aid(s): ☐Left ☐Right
Speech: ☐ Good ☐ Poor ☐ None ☐ Speech Therapy, Frequency: _____
Vision: ☐ Good ☐ Poor ☐ Blind ☐ Glasses
Swallowing: ☐ Good ☐ Poor ☐ None
Other: ☐ Smoker ☐ Smell Sensitivity ☐ Oxygen ☐Colostomy Bag ☐ Feeding Tube

Respiratory: ☐ Breathing Treatments/Inhalers: ☐ Self ☐ Assist
☐ Incentive Spirometer/Acapella ☐ Breathing Exercises
☐ Ventilator/bi pap/cpap settings and care: _____
☐ Keep head of bed up ☐Wedge pillow ☐ Trach care

Functional Limitations:

☐ Amputation ☐ Bowel/Bladder (incontinence) ☐ Contracture
☐ Hearing ☐ Paralysis ☐ Endurance
☐ Ambulation ☐ Speech ☐ Legally blind ☐ Dyspnea with Minimal Exertion

Miscellaneous:

Wound care:

Open Sores/Skin Tears/Treatment_____
Stoma care _____Dressings _____

Eye drops:

Type/frequency/which eyes_____

Pain:

Where/how often/how long, etc _____
Medication for pain? ☐Yes ☐No What else helps:_____

Mental/Behavior Conditions:

_____

_____

_____

_____

_____

Diagnosed Disorders/Medications:

☐ Depression ☐ Lethargy ☐ Past substance abuse Dementia? ☐Yes ☐No
Can client be left alone? ☐Yes ☐No Subject to wondering? ☐Yes ☐No

Symptoms:

☐ Frequent Mood Changes ☐ Hallucinations ☐ Problem Solving
☐ Short Term Memory Loss ☐ Completing Tasks ☐ Sundowning
☐ Spatial/Visual Relationships ☐ Misplacing items ☐ Poor eating
☐ Speaking/Conversing ☐ Poor Judgment ☐ Sleeping Problems
☐ Anxiety ☐ Agitation ☐ Fear
☐ Paranoia ☐ Suspicion ☐ Aggression
☐ Confusion of Time/Place ☐ Withdrawal ☐ Depression
☐ Repetition ☐Wandering ☐ Oriented
☐ Comatose

Memory Assistance:

Reminders _____ takes notes_____ reads_____ TV_____
Music_____ Books on tape_____ dry erase board_____
Suggestions_____RNS name tag y/n_____
Triggers: _____

_____

Allergies:

List: _____

Notes: _____

_____

Elimination:

Incontinence: ☐ Urination ☐ Bowels Briefs: ☐ Accident Protection ☐ Fully Incontinence
Issues: ☐ Constipation ☐ Diarrhea ☐ Urination
Other: ☐ Catheter (internal/condom) care ☐ Ostomy/care peri-care
☐ Suppository/enemas bowel program

Notes: _____

_____

Medications and Supplement:

☐ Med set up ☐ Self-administered ☐ Assist Self-Administer meds
☐ Crush and give meds – mix in ☐ Meds per gtube with flush
☐ IV ☐ Blood draws
(Fill out Medication Sheet – List all medications, etc.)

Ambulation:

Aides:
☐ Cane ☐ Walker ☐ Wheelchair ☐ Geri-Chair ☐ Scooter ☐ Crutches
☐ Weight bearing Other: ☐ Cast ☐ Brace ☐ Splint

Fall Risk:
☐ Fall Risk ☐ No Risk ☐ Poor Balance ☐ Needs Cueing
Fall precautions: _____
Use of Arms/Hands: ☐ Left ☐ Right

Misc:
☐ Remind or assist with passive/active exercises

Notes: _____

_____

_____

Transfers:

☐ No Assistance Needed ☐ Stand-by Assist ☐ Hands-On Assist ☐ Full Assist

Transfer Type:
☐ Gait Belt Required ☐ Hoyer Lift ☐ Bedrest/Turning

Transfer Risks: _____

Notes: _____

_____

Bathing, Grooming & Dressing:

☐ No Assistance Needed ☐Stand-by Assist ☐Hands-On Assist ☐Full Assist
☐ Resists Bathing ☐ Uses Shower Bench

Method:
☐ Shower ☐ Bath ☐ Sponge Bath Frequency: _____

Hygiene: ☐Dental/Denture Care ☐ Skin Care ☐ Nail Care ☐ Anti-embolic Stockings
☐Shampoo/conditioner ☐Shave ☐Massage/Wraps
☐ Other: _____

Dressing:
☐No Assistance Needed ☐ Light Assistance ☐ Heavy Assistance ☐Full Assistance
Notes: _____

_____

Meal:

Appetite: ☐ Good ☐Poor

Assistance:
☐No Assistance Needed ☐ Preparation ☐ Cooking ☐ Feeding ☐ Cleanup

Diet: ☐ Poor Nutrition ☐ Desires Improved Nutrition ☐ Special Diet

Diabetic:
Blood sugars/frequency: _____ ☐Self or ☐Assist
Insulin: ☐ Self or ☐Assist

Shopping: ☐ Self ☐ Caregiver ☐ Other _____

Meal Times: ☐ Breakfast: _____ am/pm ☐ Lunch: _____ am/pm ☐ Dinner _____ pm ☐ Snacks

Other: ☐ Swallowing issues ☐Encourage liquids
☐Limit liquids

Favorite Foods: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks:_____

Notes: _____

_____

Misc:
Special utensils/plates/colors:_____
Tube Feedings _____
Check weight/how often_____
Swallowing aids_____

Driving:

Vehicle: ☐ Client Drives Caregiver drives: ☐ Own Car ☐ Client's car ☐Other: _____
Other: ☐ Errands ☐ Doctor Appointments ☐ Payment form: ☐Credit Card or ☐Cash
Other: _____

Notes: _____

_____

Exercise:

Importance: _____ (rated 1-5) ☐ Encourage exercises
Specific exercise/rehab regimen: _____
PT/OT Therapy:_____ Frequency: _____
Standing Appointments: _____

Sleep Patterns:

Goes to Bed: _____ am/pm Wakes Up: _____ am/pm
☐ Sleeps through the Night ☐ Frequently Wakes ☐ Difficulty returning to Sleep
☐ Needs assistance at night from caregiver ☐ Naps during day: _____am/pm, length: _____

Notes: _____

_____

Equipment/Environment:

Has safety assessment been done? ☐Yes ☐No Interested in Lifeline? ☐Yes ☐No
☐Bedrails ☐ Hospital Bed ☐ Bed Commode ☐Lift Chair ☐ Raised Toilet Seat
☐ Shower Bench ☐ Handheld Showerhead ☐ Other: _____

Daily Routine

Activities Permitted:

☐ Complete Bedrest	☐ Bedrest BRP	☐ Up as Tolerated
☐ Transfer Bed/Chair	☐ Exercise Prescribed	☐ Partial Weight Bearing
☐ Independent at Home	☐ Crutches	☐ Cane
☐ Wheelchair	☐ Walker	☐ No Restrictions

Daily Routine:
Morning: _____

Afternoon: _____

Evening: _____

Activities:
Activities at Home (e.g., Reading, Board Games, Hobbies, Music, etc.: _____

_____
Activities Away from Home (Parks, Gardens, Outings, Lunches, etc.: _____

_____
Favorite Restaurants/Shops: _____

_____
Family/Friends/Neighbors: _____

REQUESTS and INSTRUCTIONS per client and/or family:

Tasks

Housekeeping:

☐ Cleaning: _____

☐ Laundry: _____

☐ Change Linens

Other: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ Petcare: Pet #1 type: _____, Name(s): _____

Pet #2 type: _____, Name(s): _____

Pet #1 Care: _____

_____

_____

_____

_____

Pet #2 Care: _____

_____

_____

_____

_____

☐ Mail Service/Mailbox, Delivery day: _____ Code/Key: _____

☐ Trash, Pickup Day: _____

☐ Check Vitals BP, O2 sat, RR, heart rate _____ how often _____

☐ Assist with making appts/personal calendar

Additional Tasks:

Notes:

Client or family signature _____ Date_____

RNS signature_____ Date_____