LEVEL OF CARE ASSESSMENT

NAME: _____ TDCJ-ID#: _____ FACILITY: _____

I. CURRENT DIAGNOSIS

A. _____ B. _____

C. _____ D. _____

E. _____ F. _____

II. FUNCTIONAL ASSESSMENT – CHECK THE APPROPRIATE CATEGORY

	INDEPENDENT	SUPERVISED	ASSISTANCE	(SPECIFY DEGREE)
MOBILITY	_____	_____	_____	_____
TRANSFERRING	_____	_____	_____	_____
BATHING	_____	_____	_____	_____
DRESSING/ GROOMING	_____	_____	_____	_____
TOILETING	_____	_____	_____	_____
EATING/DRINKING	_____	_____	_____	_____

VISION

LEFT _____

RIGHT _____

HEARING

LEFT _____

RIGHT _____

EXPRESSIVE COMMUNICATION

_____ SPEAKS AND IS UNDERSTOOD
_____ SPEAKS AND IS UNDERSTOOD WITH DIFFICULTY
_____ USES SIGN LANGUAGE
_____ USES GESTURES ONLY
_____ UNABLE TO COMMUNICATE
_____ NEEDS INTERPRETER

RECEPTIVE COMMUNICATION

_____ UNDERSTANDS ORAL COMMUNICATION
_____ UNDERSTANDS SIGN LANGUAGE
_____ LIMITED UNDERSTANDING OF ORAL COMMUNICATION
_____ DOES NOT RESPOND

CONSCIOUSNESS	_____	ALERT WAKEFULNESS
	_____	LISTLESSNESS, APATHY
	_____	LETHARGY
	_____	SEMI-COMA
	_____	COMA
MOOD DISTURBANCE	_____	NO PROBLEMS NOTED
	_____	MONTHLY
	_____	WEEKLY
	_____	DAILY
	_____	MORE THAN DAILY
ORIENTATION AND MEMORY	_____	AWARE, GOOD MENTAL CLARITY
	_____	ONLY IF REMINDED, ASSISTED
	_____	MODERATE IMPAIRMENT
	_____	SEVERE IMPAIRMENT
	_____	INCOHERENCE

III. DISABLING CONDITIONS

A. INDICATE FREQUENCY

NAUSEA	_____
VERTIGO	_____
PAIN	_____

B. CHECK THE APPROPRIATE CATEGORY

SEIZURES/ CONVULSIONS	_____	NONE NOTED
	_____	REPORTED HISTORY OF SEIZURES
	_____	CONTROLLED WITH MEDS AT ALL TIMES
	_____	CONTROLLED WITH MEDS MOST OF THE TIME
	_____	NOT CONTROLLED WITH MEDS
EDEMA	_____	NONE NOTED
	_____	SINGLE SITE – NO DRESSING
	_____	SINGLE SITE – DRESSING ORDERED
	_____	MULTIPLE SITES – NO DRESSINGS ORDERED
	_____	MULTIPLE SITES – DRESSINGS ORDERED
CONTRACTURE/ PARALYSIS	_____	NONE NOTED
	_____	ONE LIMB (EXTREMITY) AFFECTED
	_____	TWO LIMBS (EXTREMITIES) AFFECTED

_____ THREE LIMBS (EXTREMITIES) AFFECTED
_____ FOUR LIMBS (EXTREMITIES) AFFECTED

DYSPNEA
_____ NONE NOTED
_____ ON EXERTION
_____ DYSPNEIC AT REST
_____ ORTHOPNEA
_____ WITH CYANOSIS

TREMORS
_____ NONE
_____ SLIGHT
_____ MILD
_____ MODERATE
_____ SEVERE

INCONTINENCE
_____ NONE NOTED
_____ ASSISTANCE REQUIRED
_____ URINARY INCONTINENCE
_____ FECAL INCONTINENCE
_____ FECAL AND URINARY INCONTINENCE

FRAILTY
_____ NO PROBLEMS NOTED
_____ LOSES BALANCE, FALLS EASILY
_____ CAN WALK ONLY WITH ASSISTANCE
_____ BRUISES EASILY, SUSCEPTIBLE TO SKIN TEARS
_____ PHYSICAL WEAKNESS AND/OR FREQUENT EPISODES OF DISEASE PROCESS

IV. ORDERED NURSING PROCEDURES AND FREQUENCY

BLOOD PRESSURE/PULSE _____
FINGER STICK GLUCOSE _____
INHALATION THERAPY – IPPB _____
OXYGEN ADMINISTRATION _____
ORAL SUCTION _____

BOWEL/BLADDER
_____ NONE NOTED (PATIENT CONTINENT)
_____ NOT ORDERED NOR PERFORMED
_____ BOWEL TRAINING
_____ BLADDER TRAINING
_____ BOWEL/BLADDER TRAINING

RESTRAINTS
_____ NONE NEEDED/ORDERED
_____ PROTECTIVE/SUPPORTIVE DEVICES USED PRN
_____ PROTECTIVE/SUPPORTIVE DEVICES USED DAILY
_____ RESTRAINTS ORDERED AND USED DURING WAKING HOURS

_____ RESTRAINTS ORDERED AND USED CONTINUOUSLY

NON-ORAL NOURISHMENT
_____ NONE ORDERED
_____ NASO-GASTRIC (N/G) TUBE
_____ GASTROSTOMY TUBE
_____ IV FLUIDS
_____ HYPERALIMENTATION AND/OR HICKMAN THERAPY

URINARY TRACT
_____ NONE REQUIRED
_____ CATHETERIZATION – PRN
_____ FOLEY (INDWELLING CATHETER)
_____ SUPRAPUBIC CATHETER
_____ THREE WAY IRRIGATION CATHETER

INTAKE/OUTPUT
_____ NONE
_____ INDWELLING CATHETER RELATED
_____ PARENTERAL FEEDING RELATED
_____ DIALYSIS TREATMENT RELATED
_____ HYPER ALIMENTATION RELATED

OSTOMY CARE
_____ NONE REQUIRED
_____ OSTOMY WITH SELF-CARE
_____ COLOSTOMY/ILEOSTOMY – CARE GIVEN BY NURSE
_____ GASTROSTOMY – CARE GIVEN BY NURSE
_____ TRACHEOSTOMY – CARE GIVEN BY NURSE

IRRIGATIONS
_____ NONE
_____ DOUCHE
_____ ENEMA/COLOSTOMY
_____ BLADDER IRRIGATION
_____ CONTINUOUS BLADDER IRRIGATION

POSITIONING
_____ NONE ORDERED/REQUIRED
_____ TO PREVENT EDEMA OF EXTREMITIES
_____ TO IMPROVE CIRCULATION
_____ TOTAL BODY POSITION CHANGE – PARTIAL ASSISTANCE
_____ TOTAL BODY CHANGE – TOTAL ASSISTANCE

DRESSINGS
_____ NONE
_____ PROTECTIVE SUPPORTIVE MATERIAL AND/OR ORDERED SKIN CARE
_____ POST-SURGICAL AND/OR STERILE
_____ STASIS/DECUBITUS ULCERS (STERILE)

V. REHABILITATIVE SERVICES – CHECK THE APPROPRIATE CATEGORY
PLEASE INDICATE SERVICES REQUIRED FOR THIS PATIENT

PHYSICAL THERAPY
_____ RANGE OF MOTION EXERCISES
_____ GAIT TRAINING
_____ HYDROTHERAPY
_____ TRANSFER & MOBILITY TRAINING
_____ PAIN MANAGEMENT

OCCUPATIONAL
_____ REALITY ORIENTATION
_____ ACTIVITIES OF DAILY LIVING
_____ VOCATIONAL ASSESSMENT
_____ WRITTEN & VERBAL COMMUNICATION

OTHER
_____ ORIENTATION & MOBILITY TRAINING (BLIND)
_____ BRAILLE INSTRUCTION
_____ INTERPRETIVE SERVICES (INCLUDING INSTRUCTION IN SIGN LANGUAGE)
_____ SPEECH THERAPY

VI. PROFESSIONAL ASSESSMENT

CURRENT FACILITY APPROPRIATE FOR IDENTIFIED PHYSICAL DEFICITS?
YES _____ NO _____

IF NO, WHICH FACILITY IS RECOMMENDED? _____
OTHER RECOMMENDATIONS:
_____
_____
_____
_____

_____ _____
SIGNATURE DATE