FACILITY NAME

RN/MD ASSESSMENT FORM
SUPPORTING PCS DUCUMENTS
NARRATIVE

DATE:___________________

PATIENT NAME:
DATE OF BIRTH:
MEDICARE#:

1.COGNITIVE STATE

☐ ALTER MENTAL STATUS____

☐ CONFUSION____

☐ SEMICOMATOSE____

ABOVE CREATING BED CONFINEMENT STATUS UNSTEADY GAIT/FALL RISK

2. MEDICAL STATEMENT

☐ REQUIRES CARDIAC MONITORING____

☐ REQUIRES INTAVENOUS MED DRIPS____

☐ REQUIRES OXYGEN AND/OR SUCTION DEVICES, VENTILATOR______________________________________

☐ STAGE 4 DECUBITI LOCATION____

☐ MORBID OBESITY APPROX BMI____

☐ ISOLATION PRECAUTIONS____

PATIENT NAME: DATE:________________

MOBILITY LIMITATIONS

- ☐ CONTRACTURES____
- ☐ FRACTURE BONES____
- ☐ ORTHOPEDIC DEVICES:

BRACES, COLLARS, HALO, BACKBOARD ____

- ☐ PHYSICAL OR CHEMICAL

RESTRAINTS ____

PHYSICAL LIMITATIONS

- ☐ DANGER TO SELF/OTHERS____
- ☐ COMBATIVE REQUIRING AS

ABOVE PHYSICAL OR CHEMICAL ____

NARRATIVE:

____
SIGNATURE OF HEALTHCARE PROFESSIONAL

____
PRINT NAME AND TITLE CLEARLY

____
DATE SIGNED

- ☐ PHYSICIAN
- ☐ PHYSICIAN ASSISTANT
- ☐ CLINICAL NURSE SPECIALIST
- ☐ REGISTERED NURSE