AP-70.1
REV 6/78

Rhode Island Department of Social and Rehabilitative Services

Nursing and Intermediate Care Unit

Social Worker's Evaluation of need for Care in
A Nursing or Intermediate Care Facility

Date_____

Name	Sex	Date of Birth	Case Number

Address or Name of Facility and Classification	If Hospitalized, Name of Hospital	Date of Admission

A. PRESENT SITUATION

1. New Referral ☐ If in Hospital. Name of Referring Person_____
Explain how Client's needs have been met up to now and if consideration has been given to helping the Client remain at Home or to placement with Relatives', etc.

2. Re-Evaluation ☐ Date of Last Authorization_____for_____
Indicate: (A) Length of stay in this home, (B) Attitude towards home. (C) Motivation towards rehabilitation (D) Other pertinent data.

B. PHYSICAL AND MENTAL STATUS AND FUNCTIONAL CAPACITIES (Place check (✓) in appropriate spaces)

1. AMBULATION
_____ alone
_____ with cane
_____ with crutches
_____ with walker
_____ with personal assistance
_____ bed to chair only
_____ bedridden

2. BODY HYGIENE
_____ tends to toilet functions alone
_____ tends to toilet functions with help
_____ occasionally incontinent, bowel ( ) bladder ( )
_____ moderately incontinent, bowel ( ) bladder ( )
_____ chronically incontinent, bowel ( ) bladder ( )

3. PERSONAL REQUIREMENTS
_____ needs little or no help
_____ needs help bathing
_____ needs help dressing
_____ needs help feeding

4. MENTAL AND EMOTIONAL NEEDS
_____ Alert
_____ Disoriented
_____ Forgetful
_____ Confused
_____ Belligerent
_____ Withdrawn

5. SENSES

_____ normal sight	_____ normal hearing
_____ failing sight	_____ impaired hearing
_____ partially blind	_____ partially deaf
_____ blind	_____ deaf

6. OTHER IMPAIRMENTS (SPECIFY)
_____
_____
_____
_____

C. SERVICES REQUIRED

(Note: If New Case, Indicate whatever information is known to you
If Re-Evaluation, Give Name and position of person in NIC home who is helping to provide this information)

Name of person giving information _____

Position in NIC home: _____

_____Requires only general supervision, incidental medications, enemas, etc.

_____Requires the following services as checked:

( ) Dressings
( ) Catheter Irrigations
( ) Attention to colostomy by home staff
( ) Medications by Injection
( ) Extensive Oral Medications
( ) Physiotherapy
( ) Oxygen Administration
( ) Intravenous of Tube Feedings
( ) Other (Specity):

D. What attempts have been made to keep the patient in the community, through the use of community resources?

E. General description of patient's condition and services that must be performed for the patient and what the patient can do for himself or herself:

_____
Caseworker's Signature