TouchPoint: HC Assessment of Need
Subject: Test, AndrewKMS
Response Date: 11/4/2016
Completed By: Shaffer, Katherine

General Information/Entities

Case Number: 804952

To open the Facesheet Report, right click the link below and select "open in new window".

https://secure.etosoftware.com/Modules/Reporting/ViewWebiReport.aspx?reportId=111908019

To open the Entity Vendor Search Report, right click the link below and select "open in new window".
https://secure.etosoftware.com/Modules/Reporting/ViewWebiReport.aspx?reportId=68147172

DOB 12/28/2011

Assessment

Location at registration:

Currently Institutionalized

Advanced Directives

DNR

Score from Social Risk Assessment TouchPoint

Household Composition

Family Members/Caregivers:

Name:		
Name:	Trained Caregiver:	Employed:
Name:	Trained Caregiver:	Employed:
Name:	Trained Caregiver:	Employed:
Name:	Trained Caregiver:	Employed:

Specify name and age of any others in the household

Trained Caregiver Outside of the Home

Are there trained caregivers outside of the home?

Trained Caregivers:

Family Support Type:

Describe family support:

Does the family have a need?

Entities

Nursing Agency 1

Nursing Agency 2

Home Medical Equipment Provider 1

Equipment List 1 Received Date:

Equipment List 1

File Name: participant ID, year of birth, document code, date uploaded
(without spaces or punctuation)

Home Medical Equipment Provider 2

Equipment List 2 Received Date:

Equipment List 2

File Name: participant ID, year of birth, document code, date uploaded
(without spaces or punctuation)

Home Medical Equipment Provider 3

Equipment List 3 Received Date:

Equipment List 3

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Not Approved Home Medical Equipment Provider

Equipment List (Not Approved HME) Received Date:

Equipment List (Not Approved HME)

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Home Modification/Equipment Quote

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Transitional Care / Respite

Number of respite hours used

Managing physician name:

Managing Physician Phone Number:

Primary Care Physician Name:

Primary Care Physician Phone Number:

Medical Provider 1

Medical Provider 2

Medical Provider 3

Medical Provider 4

Medical Provider 5

Medical Provider 6

Medical Provider 7

Medical Provider 8

Medical Provider 9

Medical Provider 10

Unlisted Provider 1

Unlisted Provider 2

Unlisted Provider 3

Health Information

Diagnoses

Are immunizations up to date?

Immunization Needs:

Immunization Plan

Allergies

Does the child have allergies?

Is there an allergy need?

Medications

Is there a Plan of Care/Medication Administration
Record Available?

Respiratory

Is there respiratory support?

Concentrator

Oxygen

Tracheostomy

Suction

Humidifier

Apnea Monitor

Oximeter

Is there a respiratory need?

Cardiovascular

Is there a cardiovascular need?

Gastrointestinal

Ostomy

Is there a gastrointestinal need?

Nutrition

Delivery Mode:

Bolus:

Bolus comments:

Continuous:

Pump:

Are aspiration precautions in place?

Central Line:

Is there a nutrition need?

Neurological

Level of Communication

Cognitive Level

Temp Regulation

Are there seizure precautions in place?

Is there a neurological need?

Musculoskeletal

Mobility

Braces/Appliances

Is there a musculoskeletal need?

Genitourinary

Diapers

Catheterization

Ostomy

Peritoneal Dialysis

Is there a genitourinary need?

Endocrine

Blood Glucose Monitoring

Ketone Monitoring

Is there an endocrine need?

Integumentary

Skin Care

Wound Care

Sterile Dressing Changes

Is there an integumentary need?

Sensory

Hearing Aid

Cochlear Implant

Appliances/Adaptive Devices

Is there a sensory need?

Vision

Does the child have a vision impairment?

Is there a vision need?

Craniofacial

Is there a craniofacial need?

Dental

Is there routine dental care?

Is there a dental need?

Pain

Is the child having any pain?

Is there a pain need?

Autoimmune/Infectious Diseases

Does the child have an Autoimmune deficiency?

Does the child have an Infectious Disease?

Is there an autoimmune/infectious disease need?

Behavior/Emotional/Substance Abuse

Is there a Behavior/Emotional/Substance Abuse need?

Education/Therapy/Transition

Education

Education Program

Is one-to-one nursing provided by the school?

Name of Educational Program/School:

IEP/IFSP Date:

Is there an Education need?

Therapy

Does the child currently receive therapies?

Is there a therapy need?

Transition

Transition to:

Is there a transition need?

Personal Care ADLs

Is your child able to perform these self-care skills?

Eating:

Toileting:

Hygiene:

Dressing:

Chores:

Meal Preparation:

Telephone Use:

Medication:

Utilize Transportation:

Other:

Is there a Personal Care ADL need?

Funding Resources

Funding Resources:

Documentation

Cost Estimate

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Must be uploaded for initial application

Medical Report

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Physician's Letter

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Nursing Notes

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Supervisory Reports

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

ER Visit

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Hospitalization

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Other

File name: participant ID, year of birth, document code, upload date
(without spaces or punctuation)

Describe other upload(s)