

**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		HEARING		
LEFT _____		LEFT _____		
RIGHT _____		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

	<input type="checkbox"/>	THREE LIMBS (EXTREMITIES) AFFECTED
	<input type="checkbox"/>	FOUR LIMBS (EXTREMITIES) AFFECTED
DYSPNEA	<input type="checkbox"/>	NONE NOTED
	<input type="checkbox"/>	ON EXERTION
	<input type="checkbox"/>	DYSPNEIC AT REST
	<input type="checkbox"/>	ORTHOPNEA
	<input type="checkbox"/>	WITH CYANOSIS
TREMORS	<input type="checkbox"/>	NONE
	<input type="checkbox"/>	SLIGHT
	<input type="checkbox"/>	MILD
	<input type="checkbox"/>	MODERATE
	<input type="checkbox"/>	SEVERE
INCONTINENCE	<input type="checkbox"/>	NONE NOTED
	<input type="checkbox"/>	ASSISTANCE REQUIRED
	<input type="checkbox"/>	URINARY INCONTINENCE
	<input type="checkbox"/>	FECAL INCONTINENCE
	<input type="checkbox"/>	FECAL AND URINARY INCONTINENCE
FRAILTY	<input type="checkbox"/>	NO PROBLEMS NOTED
	<input type="checkbox"/>	LOSES BALANCE, FALLS EASILY
	<input type="checkbox"/>	CAN WALK ONLY WITH ASSISTANCE
	<input type="checkbox"/>	BRUISES EASILY, SUSCEPTIBLE TO SKIN TEARS
	<input type="checkbox"/>	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	<input type="checkbox"/>	NONE NOTED (PATIENT CONTINENT)
	<input type="checkbox"/>	NOT ORDERED NOR PERFORMED
	<input type="checkbox"/>	BOWEL TRAINING
	<input type="checkbox"/>	BLADDER TRAINING
	<input type="checkbox"/>	BOWEL/BLADDER TRAINING

RESTRAINTS	<input type="checkbox"/>	NONE NEEDED/ORDERED
	<input type="checkbox"/>	PROTECTIVE/SUPPORTIVE DEVICES USED PRN
	<input type="checkbox"/>	PROTECTIVE/SUPPORTIVE DEVICES USED DAILY
	<input type="checkbox"/>	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

