Effective date: 5/98, Revised 8/98; Revised 12/98; Revised 4/99; Revised 4/02

PHYSICAL STATUS REVIEW
(HEALTH RISK SCREENING TOOL)

Complete a PSR/HRST at least annually and after any hospitalization, significant change in health status, or functional or behavioral deterioration.

Name: ______________________ **ID:** __________ **Date of Birth:** __________

Address: ______________________ **Home:** __________

Name/Title of Review: ______________________ **Date of Review:** __________

ISC/Case Manager: __________ **Provider Agency:** __________

Information Source(s) (e.g., name and relationship, health record etc.):

____

Computation of Category Scores

To be completed by Reviewer.
Enter ratings for each item and compute Category Score.

Category and Item	Item Score
I. FUNCTIONAL STATUS	
A. Eating	______
B. Ambulation	+ ______
C. Transfer	+ ______
D. Toileting	+ ______
E. Day Program	+ ______
FUNC. STATUS CATEGORY SCORE	= ______
II. BEHAVIORS	
F. Self-abuse	______
G. Aggression	+ ______
H. Physical Restraint	+ ______
I. Emergency Drugs	+ ______
J. Psychotropic Medications	+ ______
BEHAVIORS CATEGORY SCORE	= ______
III. PHYSIOLOGICAL	
K. Gastrointestinal	______
L. Seizures	+ ______
M. Anticonvulsant	+ ______
N. Skin Breakdown	+ ______
O. Bowel Function	+ ______
P. Nutrition	+ ______
Q. Treatments	+ ______
PHYSIOL.CATEGORY SCORE = ______ x 2 =	______
IV. SAFETY	
R. Injuries	______
S. Falls	+ ______
SAFETY CATEGORY SCORE	= ______
V. FREQUENCY OF SERVICES	
T. Professional Health Care Serv.	______
U. Emergency Room Visits	+ ______
V. Hospital Admissions	+ ______
FREQ. OF SER CATEGORY SCORE	= ______

(**Note**: This category score is weighed. Multiply the sum of the item scores by 2.)

Check: ☐ Attached List of Current Medications (REQUIRED)

☐ Attached Additional Information (AS NEEDED)

Identification of a Health Care Level

Enter Category Scores computed in column one below AND add them together for a Total Score.

FUNCTIONAL STATUS CATEGORY SCORE	______
BEHAVIORS CATEGORY SCORE	+ ______
PHYSIOLOGICAL CATEGORY SCORE	+ ______
SAFETY CATEGORY SCORE	+ ______
FREQ. OF SER CATEGORY SCORE	+ ______
TOTAL SCORE	= ______

Count the number of #4 ratings from The Items above and enter here:

Total of # 4 ratings ______

Check if Item "Q" Treatments, was scored ____**Yes** ____**No**

Check the Health Care Level below. Use the Total Score, Number of #4 ratings and Item "Q" score to identify the Health Care Level:

Level 1: Total score 0 - 12. Three or less #4 ratings. If item "Q" is scored "YES", raise to Level 2.

Level 2: Total score 13 - 25. Three or less #4 ratings. If item "Q" is scored "YES", raise to Level 3.

**Level 3: Total score 26 - 38. Raise to Level 4 if 4 or more #4 ratings. If item "Q" is scored "YES", raise to Level 4.

**Level 4: Total score of 39 - 53. Raise to Level 5 if 4 or more #4 ratings. If item "Q" is scored "YES", raise to Level 5.

**Level 5: Total score 54 - 68. If item "Q" is scored "YES", raise to Level 6.

**Level 6: Total 69 or greater. If item "Q" is scored "NO" lower to Level 5. To score at Level 6, item "Q" must be scored "YES".

***** Levels 3 through 6 require in-depth RN Review of the PSR/HRST***

TURN TO PAGE 2 AND COMPLETE EVALUATION AND TRAINING RECOMMENDATIONS.

****RN Review**

Print Name of RN Reviewer: ______________________

Signature/Title RN Reviewer: ______________________

Date of RN Review: ______________________

Name:______________________________________

Reviewer Recommendations

Compare individual item rating scores with the Evaluation and Training matrix.
Check the needed Evaluation, Services and Training below.

Evaluation/Services:

___*Baseline data collection
___ Behavioral
___ Communication
___ Dental
___ Medical
___ *Medical specialty (psychiatry, neurology, etc.)
___ Nursing
___ Nutritional/Clinical Dietitian
___ Oral Motor (OT/Speech)
___ Personal Support Team
___ Pharmacological
___ Physical Management (PT/OT)
___ Respiratory
___ *TD Screen, standardized

*Specify in Reviewer Recommendations Section below

Training

___ Behavioral interventions
___ Emergency First Aid/CPR
___ Health Care Protocols
___ Mealtime Management-Basic (Includes: preparation, adaptive equipment, food texture and positioning)
___ Mealtime Management - Advanced (Includes: assistive techniques, emergency intervention, oral motor techniques, and troubleshooting mealtime problems)
___ Medication Administration
___ Physical Management - Basic (Includes: body mechanics, lifting and transfers)
___ Physical Management - Advanced (Includes: therapeutic positioning and specialized transfers)
___ Seizure Recognition and Management
___ Signs/Symptoms/Emergencies
___ TD Screen (DISCUS, AIMS, etc.)
___ *Individual Specific Training

*Specify in Reviewer Recommendations Section below

Reviewer Recommendations (Sign all entries):______________________________________

Name:________________________________

INSTRUCTIONS

1. Complete a PSR/HRST at least annually and after any hospitalization, significant change in health status, or functional or behavioral deterioration.
2. Print all the demographic information (name, date of birth, etc.) at the top of page 1.
3. Write the person's NAME on page 2 and 3 of the instrument.
4. Remove pages 1 and 2 from the instrument. Place these pages next to the instrument in order to record item scores as they are rated.
5. The instrument is divided into 5 categories. The CATEGORIES are FUNCTIONAL STATUS, BEHAVIORS, PHYSIOLOGICAL, SAFETY AND FREQUENCY OF SERVICES. Each CATEGORY contains several ITEMS to be rated for a total of 22 ITEMS.
6. Each ITEM includes 5 possible RATING AREAS (0, 1, 2, 3 or 4). Read ALL the RATING AREAS under each item BEFORE scoring.
7. For each of the 22 ITEMS, score ONLY one rating area, 0, 1, 2, 3 or 4, by checking the box next to the RATING AREA of the ITEM. Enter the ITEM SCORE in column one, *Computation of Category Scores,* on Page 1 in the designated blank.

- Check the box next to ITEM'S RATING:

A. Eating

☐ 0. Eats independently. May require simple adaptive equipment (hand splints, special utensil). Able to eat without assistance. Exception: meal preparation (cutting meat).

☐ 1. Requires Intermittent physical assistance AND/OR verbal prompts to eat. Has difficulty attending to task and/or needs direct physical help due to motor limitation. With assistance, is able to safely complete meal.

☐ 2. Requires constant verbal and physical help to complete a meal. Has difficulty attending to task or motor limitations which require constant physical AND/OR verbal assistance. With constant physical assistance, is able to safely complete meal.

☒ 3. Requires constant physical assistance and mealtime intervention to eat safely. Unable to obtain adequate calories and fluids without assistance. May have difficulty breathing/swallowing while eating or condition that impairs ability to eat safely. Interventions are required (specific positioning support, eating devices, presentation techniques, modifications in food/fluid consistency). May have enteral (feeding) tube, but maintains some level of oral eating.

☐ 4. Receives all nutrition through an enteral tube (gastrostomy, jejunostomy). Unable to swallow safely. All nutrition given through the tube.

- Enter the ITEM rating Score in column one on page 1:

	Category and Item	Item Score
I.	FUNCTIONAL STATUS	
	A. Eating	3
	B. Ambulation	+ 3
	C. Transfer	+ 3
	D. Toileting	+ 4
	E. Day Program	+ 2

INSTRUCTIONS (Continued)

8. Use the COMMENTS section after each CATEGORY to explain or justify ratings. Label all entries in the COMMENTS section with the letter of the ITEM, e.g., A. Eating. Initial all entries.

9. After rating each item and entering the ITEM rating score in column one, compute the CATEGORY SCORES. Four of the CATEGORY SCORES (i.e., I. Functional Status, II. Behaviors, IV. Safety and V. Frequency of Services) are determined by simply adding each of the ITEM SCORES in the category and placing the sum in the appropriate CATEGORY SCORE blank (=_____).

   The PHYSIOLOGICAL CATEGORY SCORE is WEIGHTED BY TWO. For CATEGORY III, PHYSIOLOGICAL, add each of the ITEM SCORES in the category and place the sum in the appropriate blank (=_____). Multiply this sum by 2 and enter in the appropriate blank (x2=_____).

II. BEHAVIORS

F.	Self-abuse	1
G.	Aggression	+ 0
H.	Physical Restraint	+ 1
I.	Emergency Drugs	+ 1
J.	Psychotropic Medications	+ 0
	BEHAVIOR CATEGORY SCORE	= 3

III. PHYSIOLOGICAL

K.	Gastrointestinal	2
L.	Seizures	+ 3
M.	Anticonvulsant	+ 2
N.	Skin Breakdown	+ 1
O.	Bowel Function	+ 2
P.	Nutrition	+ 1
Q.	Treatments	+ 1
	PHYSIOL.CATEGORY SCORE	= 11 x 2 = 22

(Note: This category score is weighted. Multiply the sum of the item scores by 2.)

12

10. Attach a List of the person's Current Medications. Check the box to indicate the list has been attached. Attaching a medication list is REQUIRED

Check: ☑ Attached List of Current Medications (REQUIRED)

11. Attach and Additional Information needed to clarify or support ratings (e.g., active and inactive problem list, medical specialty consultation report, etc.). Check the box to indicate Additional Information has been attached.

☑ Attached Additional Information (AS NEEDED)

INSTRUCTIONS (Continued)

12. In column 2, *Identification of Health Care Level*, on page, 1, enter each of the CATEGORY SCORES from column one. Add them together for a TOTAL SCORE.

Identification of a Health Care Level

Enter Category Scores computed in column one below AND add them together for a Total Score.

FUNCTIONAL STATUS CATEGORY SCORE	15
BEHAVIORS CATEGORY SCORE	+ 3
PHYSIOLOGICAL CATEGORY SCORE	+ 22
SAFETY CATEGORY SCORE	+ 1
FREQ. OF SERVICES CATEGORY SCORE	+ 3
TOTAL SCORE	= 44

13. Count the number of #4 ratings for all 22 ITEMS and enter in the TOTAL of #4 ratings blank.

Count the number of #4 ratings from the Items above and enter here:
Total of #4 ratings ___1___

14. Check yes or no. Was ITEM "Q", TREATMENTS, scored?

Check if Item "Q" Treatments was scored ____ Yes __X__ No

15. Use the TOTAL SCORE, TOTAL of #4 ratings, and ITEM "Q" score to identify the HEALTH CARE LEVEL 1 through 6. Circle the identified Level. If the HEALTH CARE LEVEL is 3 through 6 an in-depth review of the PSR/HRST by an RN Reviewer and completion of STEPS 16 and 17 are REQUIRED

Circle the Health Care Level below: Use the Total Score, Number of #4 ratings and Item "Q" score to identify the Health Care Level.

Level 1:	Total score 0 - 12. Three or less #4 ratings. If item "Q" is scored "YES", raise to Level 2.
Level 2:	Total score 13 - 25. Three or less #4 ratings. If item "Q" is scored "YES", raise to Level 3.
**Level 3:	Total score 26 - 38. Raise to Level 4 if 4 or more #4 ratings. If item "Q" is scored "YES", raise to Level 4.
**Level 4:	Total score of 39 - 53. Raise to Level 5 if 4 or more #4 ratings. If item "Q" is scored "YES", raise to Level 5.
**Level 5:	Total score 54 - 68. If item "Q" is scored "YES", raise to Level 6.
**Level 6:	Total 69 or greater. If item "Q" is scored "NO" lower to Level 5. To score at Level 6, item "Q" must be scored "YES".

*** Levels 3 through 6 require in depth RN Review of the PSR/HRST.*

INSTRUCTIONS (Continued)

16. Turn to page 2, *Reviewer Recommendations.* Compare individual ITEM RATINGS with those found on the two charts at the end of the instrument:
    - *Evaluation and Service Requirements Based on PSR/HRST Rating Results*
    - *Training Requirements Based on PSR/HRST Rating Results*

    Check those Evaluation/Services and/or Training needs identified based on the rating of individual ITEMS. Provide written individualized recommendations for the areas indicated, e.g., Individual Specific Training, Medical specialty, etc. Sign all entries.

Reviewer Recommendations

Compare individual item rating scores with the Evaluation and Training chart.
Check the needed Evaluation, Services and Training below.

Evaluation/Services:

__ *Baseline date collection
__ Behavioral
__ Communication
__ Dental
__ Medical
✓ *Medical specialty (psychiatry, neurology, etc.)
✓ Nursing
✓ Nutritional/Clinical Dietitian
__ Oral Motor (OT/Speech)
__ Personal Support Team
__ Pharmacological
✓ Physical Management (PT/OT)
__ Respiratory
__ *TD Screen, standardized

*Specify in Reviewer Recommendations Section below

Training

__ Behavioral interventions
✓ Emergency First Aid/CPR
✓ Health Care Protocols
✓ Mealtime Management-Basic (Includes: preparation, adaptive equipment, food texture and positioning)
__ Mealtime Management-Advanced (Includes: assistive techniques, emergency intervention, oral motor techniques, and troubleshooting mealtime problems)
✓ Medication Administration
✓ Physical Management - Basic (Includes: body mechanics, lifting and transfers)
__ Physical Management - Advanced (Includes: therapeutic positioning and specialized transfers)
__ Seizure Recognition and Management
✓ Signs/Symptoms/Emergencies
__ TD Screen (DISCUS), AIMS, etc.)
✓ Individual Specific Training

*Specify in Reviewer Recommendations Section below

Reviewer Recommendations (Sign all entries):
Medical specialties: dermatology, urology *CS*
Health Care Protocols: urinary catheter care *CS*
Individual specific training: skin care, bowel management. *CS*

17. The RN REVIEWER performs interviews and record reviews to validate PSR/HRST ratings and score computations. Changes to REVIEWER scoring by the RN REVIEWER are completed by drawing a single line through the incorrect information, entering the correct information and initialing the change. All clarifying information about a rating area entered by the RN REVIEWER is written in the COMMENTS SECTION for the appropriate ITEM and initialed. All revisions or additions to *Reviewer Recommendations* are documented using the same method.

18. After completing the in-depth review, the RN REVIEWER completes the RN REVIEW section on page 1 including the name of the RN reviewer, signature title and date of review.

****RN Review**

Print Name of Reviewer: Joan Jet
Signature/Title RN Reviewer: *Joan Jet, RN*
Date of RN Review: 11/11/00

19. Staple pages 1 and 2 to the completed pages of the instrument. File in the appropriate section of the person's record.

CATEGORY I - FUNCTIONAL STATUS

A. Eating

- ☐ 0. Eats independently. May require simple adaptive equipment (hand splint, special utensil). Able to eat without assistance. Exception: meal preparation (cutting meat).
- ☐ 1. Requires intermittent physical assistance AND/OR verbal prompts to eat. Has difficulty attending to task and/or needs direct physical help due to motor limitation. With assistance, is able to safely complete meal.
- ☐ 2. Requires constant verbal and physical help to complete a meal. Has difficulty attending to task or motor limitations which require constant physical AND/OR verbal assistance. With constant physical assistance, is able to safely complete meal.
- ☐ 3. Requires constant physical assistance and mealtime intervention to eat safely. Unable to obtain adequate calories and fluids without assistance. May have difficulty breathing/swallowing while eating or conditions that impairs ability to eat safely. Interventions are required (specific positioning support, eating devices, presentation techniques, modifications in food/fluid consistency). May have enteral (feeding) tube, but maintains some level of oral eating.
- ☐ 4. Receives all nutrition/hydration through an enteral tube (gastrostomy, jejunostomy). Unstable to swallow safely. All nutrition is given through the tube.

B. Ambulation

- ☐ 0. Ambulates independently. May use walker or other means of support without problems of safety.
- ☐ 1. Walks with minimal supervision. Requires some type of support (walker) with support of another in close proximity. The primary issue is safety during ambulation.
- ☐ 2. Uses wheelchair for primary means of mobility. May not have ability to use his/her lower body. Able to use upper body strength for repositioning. Able to maintain trunk alignment. May not recognize need to reposition on a consistent basis.
- ☐ 3. Requires assistance to change positions or shift weight in wheelchair. Has limited use of limbs. May need assistance to propel wheelchair.
- ☐ 4. Disability prevents sitting in an upright position. Requires assistance to change position, shift weight in wheelchair and/or propel wheelchair, but due to degree of musculoskeletal deficits or deformity has limited positioning options.

C. Transfer

- ☐ 0. Transfers independently. May require verbal prompts, but no physical assistance.
- ☐ 1. Needs someone to supervise the transfer for safety.
- ☐ 2. Needs physical assistance of 1 person to transfer or change position.
- ☐ 3. Needs physical assistance of 2 people to transfer or change position.
- ☐ 4. Needs lifting equipment/procedures to safely transfer. May need range of specially designed positions. May require specialized equipment due to severe spasticity, history of bone fragility, potential for injury due to size, or due to degree of physical deformity.

D. Toileting

- ☐ 0. Independently uses toilet. No assistance required or appreciated.
- ☐ 1. Minimal supervision or adaptation required. May require reminders or some verbal and physical assistance to maintain hygienic practice or manage clothing adjustments. Beyond this, minimal assistance is necessary.
- ☐ 2. Continent of bladder or bowel, constant attention is needed. Requires physical assistance to complete hygiene tasks (wiping, hand washing) and clothing repositioning. May have occasional accidents.
- ☐ 3. Incontinent of bowel or bladder. Inability to recognize elimination (loss of sensation, physical inability to manage toileting needs). May require scheduled toileting or use of incontinent briefs.
- ☐ 4. Indwelling catheter or colostomy. Has either a severely disabling medical condition or has experienced a medical crisis making elimination through the rectum or urinary tract either difficult or impossible. May be temporary or permanent. Caregivers require training related to the underlying condition and skills to manage the catheter, colostomy and/or ileostomy.

E. Days Missed at a Day Program Site due to Illness (In Last 12 Months)

- ☐ 0. None, or person does not attend due to guardian objections. No clinical restrictions.
- ☐ 1. Less than 2 days in a month due to clinical issues. Able to actively participate in Day Program, but due to chronic, stable condition or behavioral issues, may be ill or have physician appointments to monitor condition or receive treatment.
- ☐ 2. 2 to 4 days in a month due to clinical issues. Able to actively participate in Day Program, but due to chronic, stable condition or behavioral issues, may be ill or have physician appointments to monitor condition or receive treatment.
- ☐ 3. 5 to 10 days in a month due to clinical issues. Able to actively participate in Day Program, but due to chronic unstable or progressively worsening health or behavioral issues, may be ill or have physician appointments to monitor condition or receive treatment.
- ☐ 4. More than 10 days in a month or does not attend due to intensity of clinical issues. Able to actively participate in Day Program, but due to chronic unstable or progressively worsening health or behavioral issues, may frequently be ill or have physician appointments to monitor condition or receive treatment. Intensity of clinical issues prevents any attendance.

CATEGORY I - FUNCTIONAL STATUS
COMMENTS

Please identify the section (A, B, etc.) on which you are commenting

Effective date: 5/98, Revised 8/98; Revised 12/98; Revised 4/99; Revised 4/02

CATEGORY II - BEHAVIORS

F. Self Abuse

- ☐ 0. No self abuse.
- ☐ 1. Minimal self abuse, no skin breakdown. May have redness of skin.
- ☐ 2. Self abuse needing additional observation less than 2 times a month. Demonstrates behaviors that cause minor self-injury, which may require treatment, but less than twice a month.
- ☐ 3. Self abuse needing medical/nursing attention more than 2 times per month. Demonstrates behaviors that cause minor self-injury, which may require treatment, but more than twice a month.
- ☐ 4. Self-injury interferes with program, causes extensive physical harm. Self inflicted injury to the extent that he/she is not able to attend programming.

G. Aggression Toward Others and Property

- ☐ 0. No aggression.
- ☐ 1. Less than 5 incidents per month of minor aggression (verbal or physical) but no injuries.
- ☐ 2. More than 5 incidents per month of aggression without injury to others or property.
- ☐ 3. Less than 5 episodes of aggression per month with minor injuries to others (injuries not needing medical attention or property.
- ☐ 4. Episodes of aggression require increased staffing ratios or restrictive interventions.

H. Use of Physical Restraints: Restraints Defined as Restriction of Movement. These procedures are highly controlled and in most cases PROHIBITED.

- ☐ 0. Has never been restrained.
- ☐ 1. Has been restrained less than once per month in past 12 months. May include restraints used to facilitate some type of urgent medical procedure or care that without using restraint would be impossible. This instance would be rare, requiring a physician's approval. Less restrictive options would have been explored and ruled out.
- ☐ 2. Has been restrained more than once per month in past 12 months. May include restraints used to facilitate some type of urgent medical procedure or care that without using restraint would have been impossible. This instance would be rare, requiring a physician's approval. Less restrictive options would have been explored and ruled out.
- ☐ 3. Use of devices or physical restraint procedures more than 5 times per month or wears some sort of device (fencing mask, helmet) on a regular basis (at least once per day). Generally has behavioral issues (hitting, throwing objects, biting, head-banging, etc.) that cause injury to self and others. May wear protective devices.
- ☐ 4. Individual injury requiring medical attention during application of restraints or use of some sort of device twelve hours a day (fencing mask, helmet). Generally has significant behavioral issues (severe and continuous tissue damage, use of physical/mechanical restraint).

I. Use of Emergency Drugs: The use of any drug to restrict function or movement.

- ☐ 0. Has not received drugs given in an emergency to control behavior in the past 12 months. May have behavior issues, but coping skills are sufficient to calm down without the necessity of drug/medication administration.
- ☐ 1. Received medication before any medical or dental procedure. Anxiety/pain threshold has resulted in use of drugs prior to medical or dental procedure.
- ☐ 2. Has received emergency drugs to control behavior 1 time in last 12 months.
- ☐ 3. Has received emergency drugs to control behavior 2-3 times in last 12 months.
- ☐ 4. Has needed emergency drugs to control behavior 4 or more times in last 12 months.

J. Use of Psychotropic Medications (*Before rating this item consult the list of psychotropic drugs and tardive dyskinesia definition on the back of this page.)*

- ☐ 0. Receives no medication to control behavior or psychiatric disorder.
- ☐ 1. Receives 1 medication not associated with or known to cause Tardive Dyskinesia (TD) to control behavior or psychiatric disorder.
- ☐ 2. Receives 2 medications not associated with or known to cause TD to control behavior which are unchanged in the past year. May or may not be taking a "traditional" psychotropic drug, but is taking medication (e.g., Benadryl, Inderol, Tegretol) for identified behavior.
- ☐ 3. Receives more than 2 behavioral medications not associated with or known to cause TD OR behavior medications have been changed in the past year. On 2 or more medications to control behaviors OR receives 2 medications to control behavior with at least one change in past year.
- ☐ 4. Receives one or more medications associated with or known to cause TD, OR currently on a reduction/discontinuation of medication associated with TD (in the previous 30-90 days), OR anyone on metoclopramide (Reglan), regardless of the reason.

CATEGORY II - BEHAVIORS

TARDIVE DYSKINESIA (TD) DEFINITION

A potentially severe movement disorder resulting from the use of antipsychotic or other psychotropic medications. It is characterized by involuntary, jerky movements of the face, jaw, tongue, trunk and limbs. It may effect swallowing and/or respirations.

PSYCHOTROPIC DRUGS ASSOCIATED WITH TD AS OF 1998

(This is not an all inclusive list)

ANTIPSYCHOTICS

Acetophenazine (Tindal)
Butaperazine (Repoise)
Chlorpromazine (Thorazine)
Chlorprothixene (Taractin)
*Clozapine (Clozaril)
Fluphenazine (Prolixin/Permitil)
Haloperidol (Haldol)
Loxipine (Loxitane)
Mesoridazine (Serentil)
Molindone (Moban)
*Olanzapine (Zyprexa)
Perphenazine (Trilafon)
Pimozide (Orap)

ANTIPSYCHOTICS (cont.)

Prochlorperazine (Compazine)
Promazine (Sparine)
Resperine (Serpasil)
* Risperidone (Risperdal)
*Sertindole (Serlect)
Thioridazine (Mellaril)
Thiothixene (Navane)
Trifluoperazine (Stelazine)
Triflupromazine (Vesprin)

COMBINATION

Perphenazine/Amitriptyline
(Trilafon/Etrafon)

ANTIDEPRESSANTS

Amoxapine (Asendin)
Amitriptyline (Elavil)
Desipramine (Norpramine)
Doxepin (Sinequan)
Imipramine (Tofranil)
Nortripyline (Pamelor)

OTHERS

Chlordiazepam (Librium)
Methylphenidate (Ritalin)
Metoclopramide (Reglan)
Pemoline (Cylert)

*May not cause TD or may be associated with TD at a far lower rate than traditional antipsychotic medications. These are usually referred to as "atypical" antipsychotic medications.

COMMENTS

Please identify the section (F, G, etc.) on which you are commenting

Effective date: 5/98, Revised 8/98; Revised 12/98; Revised 4/99; Revised 4/02

CATEGORY III - PHYSIOLOGICAL

K. Gastrointestinal (GI) Conditions (includes vomiting, reflux, heartburn or ulcer) ***(Before rating this item consult the list of GI drugs and gastroesophageal reflux definition on the back of this page.)***

- ☐ 0. None. No history or current status of and GI concerns.
- ☐ 1. Occasional episodes of GI symptoms in absence of acute illness. Health is very stabilized, only has an occasional episode of GI symptoms (2 or less per month). GI distress occurs with no apparent explanation.
- ☐ 2. More than 3 episodes of GI symptoms per month. Health is stable with occasional episodes of GI symptoms, but symptoms occur
  3 - 6 times a month. A documented pattern of incidents may be developing. These episodes are more likely associated with a disorder of the stomach or GI tract instead of following an acute illness like the flu.
- ☐ 3. More than 6 episodes of GI symptoms per month. OR coughing within 1-3 hours after meals or during the night, OR "hand-mouthing" where person attempts to stick hand down throat (mostly at night or around mealtimes), OR has a history of GI bleeding, OR a current diagnosis of gastroesophageal reflux (GER).
- ☐ 4. GI condition requiring hospital admission in past 12 months. (A GI condition requiring hospitalization could include GI bleeding, vomiting, persistent dehydration, reflux-causing aspiration, intestinal infections, parasites, impaction and/or obstruction) OR receives more than one medication for GER.

L. Seizures

- ☐ 0. No seizure in lifetime or by history only.
- ☐ 1. No seizure in last 2 years. Has a history of seizure activity, but has been seizure-free for past 2 years. May or may not be on anticonvulsant medication.
- ☐ 2. Less than 1 seizure per month which DOES NOT interfere with functional activity.
- ☐ 3. Major seizure activity that DOES interfere with functional activities. Generalized seizures more than once a month, OR seizure activity (any classification) more than once a month which interferes with functional activities (work, school, recreation).
- ☐ 4. Has required hospital admission for seizures in the past 12 months. Any classification of seizure requiring a hospital ADMISSION (not just ER visit) to manage problems related to excessive seizure activity.

M. Anticonvulsant Medication Use (if prescribed for behavioral concerns, rate under item J) ***(Before rating this item consult the list of anticonvulsant drugs on the back of this page.)***

- ☐ 0. None. Not on an anticonvulsant.
- ☐ 1. Use of SINGLE anticonvulsant which has NOT CHANGED in the past year.
- ☐ 2. Use of 2 anticonvulsant medications which have NOT CHANGED in the past year.
- ☐ 3. Use of 3 or more medications, OR any change in anticonvulsant type or dosage in past 12 months, OR receiving felbamate (Felbatol) or valproic acid (Depakene or Depakote) in combination with any other anticonvulsant medication.
- ☐ 4. ER visit, OR hospitalization due to anticonvulsant toxicity in past 12 months.

N. Skin breakdown

- ☐ 0. None. Skin breakdown is not a problem.
- ☐ 1. Red or dusky color of skin. Skin is reddened or has signs of poor circulation, especially in the area of the buttock, elbow, heel and/or hip.
- ☐ 2. Either currently has, or has had broken skin in last 12 months, OR has a history of areas broken skin. Areas of susceptible skin breakdown include the buttock, elbow, heel, hips or possible pressure areas identified by bony protrusions, especially if there are musculoskeletal deformities.
- ☐ 3. Within the past 12 months a pressure sore has developed which required more than 3 months to heal, OR has a condition directly associated with skin vulnerability (examples include spina bifida, spinal cord injury, nutritional compromise, diabetes mellitus).
- ☐ 4. The skin condition required recurrent medical treatment or hospitalization in past 12 months.

O. Bowel Function ***(Before rating this item consult the list of bowel drugs on the back of this page.)***

- ☐ 0. No bowel elimination problems. No problems with intestinal tract. No history or present condition of constipation or diarrhea.
- ☐ 1. Bowel elimination is easy to manage with diet. May receive a diet modification or fiber supplement.
- ☐ 2. Bowel elimination is easy to manage with diet and routine supplements. Has slight problems with constipation requiring intermittent or routine stool softener.
- ☐ 3. Daily management of bowel elimination requires on-going observation and preventative measures including enemas AND/OR manual impaction assessment. Has recurrent problem with constipation requiring 3-6 suppositories per month, OR one or more enemas. Experiences episodes of intermittent diarrhea, OR requires more than 1 medication to prevent constipation. May require manual assessment for impaction.
- ☐ 4. Any hospitalization in past 12 months required to treat an impaction or bowel obstruction. Has required a physician office visit or has been hospitalized to treat constipation, OR history of any hospitalizations for a bowel obstruction.

Effective date: 5/98, Revised 8/98; Revised 12/98; Revised 4/99; Revised 4/02

CATEGORY III - PHYSIOLOGICAL

GASTROINTESTINAL (GI) DRUGS

Axid (nizatidine)
Carafate (Sucrulfate)
Gaviscon (antacid)
Gelusil (antacid)
Maalox (antacid)
Milk of Magnesia
Mylanta (antacid)
Pepcid or Pepcid AC (famotidine)
Pepto Bismol (bismuth subsalicylate)
Prevacid (lansoprazole)
Prilosec (omeprazole)
Propulsid (cisapride)
Reglan (metoclopramide)
Rolaids (antacid)
Sucralfate (carafate)
Tagamet (cimetidine)
Tums (antacid)
Zantac (ranitidine)

ANTICONVULSANT DRUGS

Acetazolamide (Diamox)
Carbamazepine (Tegretol, Tegretol XR)
Clonazepam (Klonopin, Clonopin)
Clorazepate (Tranxene)
Divalproex sodium (Depakote)
Ethosuximide (Zarontin)
Felbamate (Felbatol)
Gabapentin (Neurontin)
Lamotrigine (Lamictal)
Lorazepam (Ativan)
Methsuximide (Celontin)
Phenobarbital
Phenytoin (Dilantin)
Primidone (Mysoline)
Tiagabine (Gabatril)
Topiramate (Topamax)
Valproic acid (Depakene, Depakote)

BOWEL DRUGS

Colace (docusate sodium) ....stool softener
Chronulac (lactulose) ....laxative
Citroma (magnesium citrate)......................laxative
Citrucel (methylcellulose) ....bulk laxative
Dulcolax (bisacodyl) ....stimulant laxative
epsom salts (magnesium sulfate).................laxative
Ex-Lax (phenolphthalein, yellow) ....stimulant laxative
Fiber Con (calcium polycarbophil) ....bulk laxative
Fleet Phospho-soda (sodium phosphates) ....enema
Glycerine suppository ....laxative
Metamucil (psyllium)............................bulk laxative
Milk of Magnesia (magnesium hydroxide)...laxative
Mineral oil (liquid petrolate) ....lubricant laxative
Modane (phenolphthalein, white) ....stimulant laxative
Peri-colace (docusate casanthranol) ....stool softener/ laxative
Senokot (senna) ....stimulant laxative
Surfak (docusate calcium) ....stool softener

COMMENTS

Please identify the section (K, L, M, N or O) on which you are commenting

CATEGORY III - PHYSIOLOGICAL
(continued)

P.Nutrition

- ☐ 0. Within ideal body weight range and is able to maintain weight. Requires no diet modifications, prescribed nutritional supplements or intervention to maintain health.
- ☐ 1. Is slightly above or below ideal body weight range. May require extra calories or some dietary restrictions. Health generally stable, though weight not within ideal range. May require additional calories through supplemental products or snacks, OR may require dietary restrictions (single servings at mealtime, low fat and low calorie foods).
- ☐ 2. Is well managed on a prescribed diet (Low Sodium, Low Fat/Cholesterol, calorie controlled, etc.). Within desired weight range, but has a diet prescription for health maintenance or health concerns which have been under control for the past 12 months.
- ☐ 3. Is on a prescribed diet with a history of weight instability OR nutritional risk which requires nutrition status monitoring within past 12 months. Has displayed unstable nutritional status episodes or trends in past 12 months which have produced health issues requiring intervention to maintain health. Risk factors to monitor are:
  - ___ inability to reach or maintain desired body weight
  - ___ unplanned changes/trends in body weight
  - ___ a chronic medical condition which affects nutritional status (diabetes mellitus, anemia, renal or hepatic disease, GI disorder, impaction, decubitus ulcer, etc.)
  - ___ fluid intake levels specific to nutrition
  - ___ difficulty consuming adequate intake, poor appetite or frequent meal refusals
  - ___ food allergies or intolerance which limits intake of major food groups
- ☐ 4. Nutritional status unstable. High nutritional risk with an unstable nutritional status. Requires intensive nutritional intervention to address any of the following conditions:
  - ___ unplanned weigh loss> 10% of usual weight in past 12 months
  - ___ morbid obesity (body weight 100 pounds greater than, or twice the desired weight range)
  - ___ hospitalization and/or treatment in past 12 months for recurrent aspiration pneumonia, choking episodes, GI bleeding, unresolved diarrhea, vomiting or unresolved decubitus ulcer
  - ___ inability to consume an adequate diet due to chewing or swallowing disorder
  - ___ gastrostomy or jejunostomy tube placement, OR complications with existing enteral tube in the last 12 months

Q. Treatments (if any apply, score is 4 - please all that pertain) EACH?

- ☐ Tracheotomy that requires suction.
- ☐ Ventilator dependent.
- ☐ Nebulizer treatments. Receives medications such as Ventolin or Theophylline, by oxygen mist nebulizer.
- ☐ Deep suction. Requires deep suction which means entering a suction catheter 6" or more into or below the voice box either via tracheotomy, oral or nasal routes.
- ☐ Diabetic requiring insulin. Requires complex medication calculations.
- ☐ Has a condition that requires hands-on treatment by a professional nurse that CANNOT be taught and delegated to a non-licensed person. Has a chronic condition that requires professional nursing assessment and evaluation, including but no limited to:
  - ___ medication therapy requiring intramuscular or intravenous injections or hemaport irrigations
  - ___ catheterization requiring sterile technique
  - ___ physician ordered treatments that CANNOT be delegated to a non-licensed person
  - ___ sterile dressing/wound treatments routinely performed only in clinical setting or by licensed practitioners
  - ___ individuals in acute and/or end stages of liver, lung or kidney disease
  - ___ terminal illness (cancer) or persons with progressive neurological disorders (San Phillipo Syndrome, Multiple Sclerosis, Huntington's Chorea) when multiple systems problems begin occurring which require licensed intervention.

CATEGORY III - PHYSIOLOGICAL COMMENTS

Please identify the section (P or Q) on which you are commenting

CATEGORY IV - SAFETY

R. Injuries

- ☐ 0. No injury or minor bruises requiring no medical intervention.
- ☐ 1. Bruises or cuts less than 1 to 2 times per year requiring nursing/medical attention.
- ☐ 2. Bruises or cuts requiring nursing attention or first aid occurring 3 or more times a year. Can be due to safety problems, self-abuse, etc., but most occur more than 3 times in the past 12 months.
- ☐ 3. Injury requiring medical attention in the past year. Sustained an injury which has required medical intervention or emergency room treatment (sutures, casting a fracture).
- ☐ 4. Major injuries requiring hospital admission. Has documented evidence of fracture or other major trauma which has required hospital admission.

S. Falls

- ☐ 0. No falls.
- ☐ 1. 1 - 3 falls per year.
- ☐ 2. 4 - 6 falls per year.
- ☐ 3. More than 6 falls per year.
- ☐ 4. Any fall which results in fracture OR hospital admission due to injuries.

CATEGORY V - FREQUENCY OF SERVICE

T. Professional Health Care Services

- ☐ 0. No visits other than annual and/or quarterly health assessment.
- ☐ 1. Required 2 visits per quarter on an average over one year period to health care provider(s).
- ☐ 2. Required 1 - 2 visits per month on average to health provider(s) OR required daily nursing services greater than 14 days continually in past 12 months.
- ☐ 3. Required 3 visits per month on average to health care providers.
- ☐ 4. Required 3 visits per month to health care providers plus emergency appointments.

U. Emergency Room Visits

- ☐ 0. No Emergency Room visits.
- ☐ 1. Emergency Room visit due to physician absence or non-emergency situation.
- ☐ 2. One Emergency Room visit in last year for acute illness or injury.
- ☐ 3. More than one Emergency Room visit for acute illness or injury in last year.
- ☐ 4. Any Emergency Room visits in the last year for acute illness or injury that resulted in hospital admission.

V. Hospital Admission

- ☐ 0. No hospital admissions.
- ☐ 1. Hospital admission for scheduled surgery or procedure.
- ☐ 2. Hospital admissions for acute illness.
- ☐ 3. 2 or more hospital admissions for acute illness in the past 12 months.
- ☐ 4. Transfer to ICU during hospitalization in past 12 months.

CATEGORY IV - SAFETY
COMMENTS

Please identify the section (R or S) on which you are commenting

CATEGORY V - FREQUENCY OF SERVICES
COMMENTS

Please identify the section (T, U or V) on which you are commenting

TRAINING REQUIREMENTS BASED ON PSR/HRST RATING RESULTS

Effective date: 5/98: Revised 12/98

PSR/HRST RATING AREAS / TRAINING NEEDS	FUNCTIONAL STATUS					BEHAVIORS					PHYSIOLOGICAL							SAFETY		FREQ. SERV.		
	A EATING	B AMBULATION	C TRANSFER	D TOILETING	E DAYS MISSED AT DAY PROGRAM	F SELF ABUSE	G AGGRESSION	H USE PHYSICAL RESTRAINT	I USE EMERGENCY DRUGS	J USE PSYCHOTROPIC MEDS	K GASTROINTESTINAL CONDITIONS	L SEIZURES	M ANTICONVULSANT MED	N SKIN BREAKDOWN	O BOWEL FUNCTION	P NUTRITION	Q TREATMENTS	R INJURIES	S FALLS	T PROFESSIONAL HEALTH SERVICES	U EMERGENCY ROOM	V HOSPITAL ADMISSIONS
Behavioral Intervention	2 / 3			2 / 3		1 2 / 3 4	1 2 / 3 4	2 / 3 4	2 / 3 4	1 2 / 3 4												
Emergency First Aid/CPR	← ALL DIRECT SERVICE STAFF CERTIFIED →																					
Health Care Protocols	3 4	3 4	3 4	4		4	3 4	3 4	1 2 / 3 4		3 4	3 4	4	3 4	3 4	3 4	4	3 4				
Individual Specific	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	2 / 3 4	2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4
Mealtime Management - (Prep. Adapt. equip., food texture, positioning)	1 2 / 3															1 2 / 3 4						
Mealtime Management - (Assistance techniques, emer. Interventions, oral motor techniques	3 4															3 4						
Medication Administration	3 4	4		3 4					1 2 / 3 4	1 2 / 3 4			1 2 / 3 4		2 / 3							
Physical Management (Body Mechanics, lifting and transfers)		2	2											3 4								
Physical Management (Therapeutic positioning and special transfer)		3 4	3 4											3 4								
Seizure Recognition and Management																						
Signs/Symptoms/Emergencies	3 4				2 / 3 4	4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4		3 4	3 4	3 4	3 4	3 4	3 4	4	3 4	3 4	3 4	3 4	3 4
TD, Standardized										3 4	4											

Evaluation and Services

~~TRAINING~~ REQUIREMENTS BASED ON PSR/HRST RATING RESULTS — Effective date: 5-98; Revised 2/98

TYPES OF EVALUATIONS AND SERVICES \ PSR/HRST RATING AREAS	FUNCTIONAL STATUS					BEHAVIORS					PHYSIOLOGICAL							SAFETY		FREQ. SERV.		
	A EATING	B AMBULATION	C TRANSFER	D TOILETING	E DAYS MISSED AT DAY PROGRAM	F SELF ABUSE	G AGGRESSION	H USE PHYSICAL RESTRAINT	I USE EMERGENCY DRUGS	J USE PSYCHOTROPIC MEDS	K GASTROINTESTINAL CONDITIONS	L SEIZURES	M ANTICONVULSANT MED	N SKIN BREAKDOWN	O BOWEL FUNCTION	P NUTRITION	Q TREATMENTS	R INJURIES	S FALLS	T PROFESSIONAL HEALTH SERVICES	U EMERGENCY ROOM	V HOSPITAL ADMISSIONS
Baseline Data Collection	3 4			3 4		3 4	3 4	3 4			2 / 3 4	3 4		2 / 3 4	3 4	3 4	4	3 4	3 4	3 4	3 4	3 4
Behavioral						3 4	3 4	1 2 / 3 4	1 2 / 3 4	1 2 / 3 4												
Communication (aug.com/speech)																						
Dental						2 / 3 4	2 / 3 4		1	1 2 / 3 4	3 4					3 4						
Medical				3 4	3 4	3 4	3 4			1 2 / 3 4						3 4	4			3 4	3 4	3 4
Medical Specialty: see code				GE or UR / 3 4						PS	GE / 3 4	NE / 3 4	NE / 3 4	DE / 4	GE / 4	GE / 4						
Nursing**					3 4										4	3 4	4	4	4			
Nutritional/Clinical Dietitian	3 4										3 4			3 4	3 4	3 4	4					
Oral Motor (OT/Speech)	3 4															3 4						
Personal Support Team									1	1 2 / 3 4						3 4	3	3 4	4	3 4	3 4	3 4
Pharmacological		2 / 3 4	2 / 3 4						2 / 3 4	2 / 3 4						3 4	4					
Physical Management		3 4	3 4											3 4	3 *4			3 *4	3 4			
Respiratory	3 4										4					4	4					3 4
TD Screen Standardized									3 4	3 4												

CODES: DE = dermatology GE = gastroenterology NE = neurology PS = psychiatry UR = urology * = if non-ambulatory ** = Nursing Assessment Required at Health Care Levels 3, 4, 5 and 6

NOTES

Date Document Received to Knoxville Regional Office_____
Date Filed n Regional Office Central File/Initials_____

Registered Nurses East

Individual Specific /Instructions
Health/Wellness

Individual_____ DOB_____
PSR Level/Date_____ Functional_____ Behavioral_____ Physiological_____
_____Safety_____ Frequency of Services_____

This document will serve as a teaching tool utilized though train the trainer concept, to provide staff instructions in the care of the person in relation to health and wellness (Example Staff was trained in the signs and symptoms of constipation, signs and symptoms of GERD, and health care plan).

Instructions:

Staff who received train the trainer information (signature indicates, you understand what has been explained to include actions to be taken, and have had an opportunity to ask questions)

Staff Supervisor Responsible for ensuring information is shared with appropriate staff, involved in the care of the individual

Information Source (Check all appropriate boxes)

- ☐ Health and Wellness Guide
- ☐ DD Nurse Protocols
- ☐ Medications
- ☐ Psychotropic Medications
- ☐ Best Practice Guidelines
- ☐ State Policy/Procedures
- ☐ Other_____

Registered Nurse Signature/Title_____ Date_____

White Original Individual Personal Home Record
White NCR RN Work File
White NCR Regional Nursing Director

Contemplate® HRST: Health Risk Screening Tool

Installation Instructions for Windows® 95/98 & NT 4.0:

IMPORTANT NOTICE: This single user version of the HRST program is designed to be installed only on the C: Drive of your computer. Please do not change the default drive and directory during the Setup process.

1. Insert the HRST disc into your CD Drive.
2. Click "CONTINUE" and follow the instructions on the screen to install the necessary files. For this version of the HRST program, do not change the destination folder, Click "OK". Next, click the "Typical" installation button.
3. If AutoPlay is disabled, install the program by running the Setup.exe file on the HRST CD. Click the START button on the Windows(r) Menu Bar, then RUN D:\Setup.exe (where D:\ = CD Drive).
4. To start the HRST program, click the HRST icon in the HRST folder of the Windows® Programs Menu.

NOTE: It is recommended that all other applications be closed when installing the HRST program. In some situations, however, the following message may occur during installation: "Setup could not write to the file 'xxx.dll.' This file is currently be used by another application. Close any open applications."

If this message appears, choose the IGNORE option each time the message occurs and continue the HRST installation. The HRST setup will continue normally.

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