

STATE OF HAWAII
Level of Care (LOC) Evaluation

1. NAME (Last, First, Middle Initial)	2. BIRTHDATE
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3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY:

SECONDARY:

II. COMATOSE No Yes If "Yes," go to **XIV**.

III. VISION / HEARING / SPEECH:

[0] a. Individual has normal or minimal impairment (with/without corrective device) of: Hearing Vision Speech

[1] b. Individual has impairment (with/without corrective device) of:
 Hearing Vision Speech

[2] c. Individual has complete absence of:
 Hearing Vision Speech

IV. COMMUNICATION:

[0] a. Adequately communicates needs/wants

[1] b. Has difficulty communicating needs/wants

[2] c. Unable to communicate needs/wants

V. MEMORY:

[0] a. Normal or minimal impairment of memory

[1] b. Problem with [] long-term or [] short-term memory.

[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS/BEHAVIOR: (refer to instructions)

[0] a. Oriented (mentally alert and aware of surroundings).

[1] b. Disoriented (partially or intermittently; requires supervision).

[2] c. Disoriented and/or disruptive.

[3] d. Aggressive and/or abusive.

[4] e. Wanders at Day Night Both, or in danger of self-inflicted harm or self-neglect.

VII. FEEDING/MEAL PREPARATION:

[0] a. Independent with or without an assistive device.

[1] b. Feeds self but needs help with meal preparation.

[2] c. Needs supervision or assistance with feeding.

[4] d. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:

[0] a. Independent with or without a device.

[2] b. Transfers with minimal /stand-by help of another person.

[3] c. Transfers with supervision and physical assistance of another person.

[4] d. Does not assist in transfer or is bedfast.

XI. MOBILITY / AMBULATION: (refer to instructions)

[0] a. Independently mobile with or without device

[1] b. Ambulates with or without device but unsteady / subject to falls.

[2] c. Able to walk/be mobile with minimal assistance

[3] d. Able to walk/be mobile with one assist.

[4] e. Able to walk/be mobile with more than one assist.

[5] f. Unable to walk.

X. BOWEL FUNCTION / CONTINENCE:

[0] a. Continent

[1] b. Continent with cues.

[2] c. Incontinent (at least once daily).

[3] d. Incontinent (more than once daily, # of times _____).

XI. BLADDER FUNCTION / CONTINENCE:

[0] a. Continent

[1] b. Continent with cues.

[2] c. Incontinent (at least once daily).

[3] d. Incontinent (more than once daily, # of times _____).

XII. BATHING:

[0] a. Independent bathing.

[1] b. Unable to safely bathe without minimal assistance and supervision.

[3] c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:

[0] a. Appropriate and independent dressing, undressing and grooming.

[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).

[2] c. Physical assistance needed on a regular basis.

[3] d. Requires total help in dressing, undressing, and grooming.

XIV. TOTAL POINTS:

Comatose = 30 points

Total Points Indicated: _____

XV. MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode)
 Attach additional sheet if necessary

	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:
 Attach additional sheet if more space is needed.

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APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type)

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XVII. SKILLED PROCEDURES: D = Daily Indicate number of times per day L = Less than once per day N = Not applicable / Never}

D	L	N	
#	√	√	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
___	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in ventilator dependent person.
___	<input type="checkbox"/>	<input type="checkbox"/>	Tracheostomy care/suctioning in non-ventilator dependent person.
___	<input type="checkbox"/>	<input type="checkbox"/>	Nasopharyngeal suctioning in persons with no tracheostomy.
___	<input type="checkbox"/>	<input type="checkbox"/>	Total Parenteral Nutrition (TPN) {Specify number of hours per day.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Maintenance of peripheral/central IV lines.
___	<input type="checkbox"/>	<input type="checkbox"/>	IV Therapy {Specify agent & frequency.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers (Stage III and above).
___	<input type="checkbox"/>	<input type="checkbox"/>	Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Instillation of medications via indwelling urinary catheters {Specify agent.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent urinary catheterization.
___	<input type="checkbox"/>	<input type="checkbox"/>	IM/SQ Medications {Specify agent.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with administration of oral medications {Explain}
___	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulties and/or choking.
___	<input type="checkbox"/>	<input type="checkbox"/>	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? <input type="checkbox"/> Yes <input type="checkbox"/> No
___	<input type="checkbox"/>	<input type="checkbox"/>	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. {Specify reason person at risk for aspiration.}
___	<input type="checkbox"/>	<input type="checkbox"/>	Initial phase of Oxygen therapy; Oxygen therapy requiring bronchodilators.
___	<input type="checkbox"/>	<input type="checkbox"/>	Complicating problems of patients on <input type="checkbox"/> renal dialysis, <input type="checkbox"/> chemotherapy, <input type="checkbox"/> radiation therapy, <input type="checkbox"/> with orthopedic traction. (Check problem(s) and describe)
___	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral problems related to neurological impairment. (Describe)
___	<input type="checkbox"/>	<input type="checkbox"/>	Other {Specify condition and describe nursing intervention.}
<input type="checkbox"/> Yes	<input type="checkbox"/> No		Therapeutic Diet (Describe)
<input type="checkbox"/> Yes	<input type="checkbox"/> No		Restorative Therapy (check therapy and submit/attach evaluation and treatment plan: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech

XVIII. SOCIAL SITUATION:

A. Person can return home Yes No Residential setting can be considered as an alternative to facility? Yes No

B. If person has a home, caregiving support system is willing to provide/continue care. Yes No

Caregiver requires assistance? Yes No

Assistance required by Caregiver:

C. Caregiver name (PRINT Last, First, Middle Initial):

Name: _____ Relationship: _____
Address: _____ Phone: (808) _____ Fax: (808) _____

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT, ANTICIPATED PLACEMENT DATE AND REQUESTED PLACEMENT OF THE PATIENT.

PHYSICIAN'S SIGNATURE: _____ **DATE:** ____/____/____

Physician's Name (TYPE): _____