STATE OF NEW JERSEY
DEVELOPMENTAL DISABILITIES
NURSING ASSESSMENT FORM (NAF)

Revised 2/22/06

Prepared by DD Planning Institute
New Jersey Institute of Technology

Prepared for State of New Jersey
Division of Developmental Disabilities

Consumer Name/
MIS Number

DD Center Name/
Cottage Name

Respondent Name/
Respondent ID Number

Date Completed ____ ____/ ____ ____/ ____ ____

PURPOSE

THIS ASSESSMENT COLLECTS FACTUAL INFORMATION ABOUT THE CONSUMER.

YOU CAN HELP BY ANSWERING SPECIFIC QUESTIONS ABOUT THIS INDIVIDUAL BECAUSE OF YOUR SPECIALIZED EXPERTISE AND TRAINING.

PLEASE COMPLETE THIS FORM ON THE BASIS OF YOUR OBSERVATION OF THE CONSUMER'S RECENT ACTUAL FUNCTIONING OR SITUATION, NOT ON WHAT YOU THINK MIGHT BE POSSIBLE IN THE FUTURE.

THANK YOU FOR YOUR ASSISTANCE.

1. Please indicate whether the consumer has been **DIAGNOSED** with any of these developmental disabilities.

		NO	YES
a.	Cerebral Palsy	0	1
b.	Epilepsy/Seizure Disorder	0	1

If has epilepsy/seizure disorder, please indicate the time period since the last seizure.

In Last 3 Months	4-6 Months	7-12 Months	More than a Year
1	2	3	4

c.	Spina Bifida	0	1
d.	Down's Syndrome	0	1

2. Please provide information on the **consumer's medical status** by completing the following 3 sections as described below.

A. Please circle whether or not the consumer has had any of the following **DIAGNOSED** conditions or illnesses in the **last 2 years**.

B. **ONLY IF CONSUMER HAS CURRENT DIAGNOSIS,** circle whether consumer has seen or been reviewed by a doctor during the **last 3 months SPECIFICALLY** for this condition.

C. **ONLY IF CONSUMER HAS CURRENT DIAGNOSIS,** circle whether **THIS CONDITION** needs medical attention by a doctor **more often than once per year**.

		IF HAS CONDITION(S), ANSWER BOTH					
		A. Has Condition?		B. Seen or Reviewed by Doctor in the **Last 3 Months** for this Condition?		C. Condition Needs Medical Attention **More Than Yearly**?	
		NO	YES	NO	YES	NO	YES
a.	**Respiratory Conditions** such as asthma, emphysema, cystic fibrosis?	0	1	0	1	0	1
b.	**Cardiovascular/Circulatory Conditions** such as heart disease, high blood pressure, anemia or other blood disorders?	0	1	0	1	0	1
c.	**Digestive Conditions** such as ulcers, colitis, liver/bowel disorders?	0	1	0	1	0	1
d.	**Swallowing Conditions** such as difficulty swallowing, gastric reflux, aspiration?	0	1	0	1	0	1
e.	**Bladder or Kidney Conditions**?	0	1	0	1	0	1
f.	**Conditions of the Nervous System** such as multiple sclerosis, organic brain syndrome, Parkinson's disease?	0	1	0	1	0	1
g.	**Hormone or Endocrine Conditions** such as diabetes, thyroid problems, hormone replacement therapy?	0	1	0	1	0	1
h.	**Chronic Conditions related to Skin, Hair, or Nails** such as thick toenails, eczema, dermatitis?	0	1	0	1	0	1
i.	**Allergies** such as those for foods, medications, or seasonal?	0	1	0	1	0	1

3. Please indicate whether the consumer has been seen by or utilized any of the following health services in the **last 3 months** in any setting for routine or non-routine care.

		NO	YES
a.	Been to an Emergency clinic/room in an **outside** hospital?	0	1
b.	Stayed overnight in an **outside** hospital?	0	1
c.	Seen a podiatrist (specialist for feet) in or outside the DD Center?	0	1

4. Please indicate whether any medical treatments/services have been performed on consumer in the **last 3 months** in any setting for routine or non-routine care.

		NO	YES
a.	Use of special bowel or colostomy equipment – not laxatives or enemas?	0	1
b.	Catheterization or catheter care?	0	1
c.	Suctioning at least once a day to remove internal fluids?	0	1
d.	Special breathing or respiratory care (e.g., inhalers or oxygen)?	0	1
e.	Turning or positioning to protect skin integrity?	0	1
f.	Dressing or wound care?	0	1
g.	Dialysis or use of kidney machine?	0	1
h.	Any medications by injection or intravenously, not immunizations?	0	1
i.	Staff assistance due to choking incident(s) (e.g., staff had to clear food from mouth with hand, Heimlich Maneuver, etc.)?	0	1

5. Regardless of where the consumer lives, what services might be necessary, if any, from these health care professionals?

		None Needed	Needed On An Occasional Basis	Needed On a Frequent Basis
a.	Podiatrist (specialist for feet)	1	2	3
b.	Nursing	1	2	3
c.	Physician (General Practice)	1	2	3

6. Which answer best describes the consumer's **vision** in the **last 4 weeks**?

IF WEARS GLASSES, INDICATE STATUS OF VISION WITH GLASSES.

1. Normal range
2. Mild impairment (color blind or has difficulty seeing small objects)
3. Moderate impairment (has trouble with depth perception, seeing curbs, or recognizing people by sight, blind in one eye, etc.)
4. Severe impairment (sees only light or shadow)
5. Profound impairment (total blindness)

7. Please indicate any **adaptive or special equipment** that the consumer used at any time in the l**ast 3 months**.

IF PRESCRIBED, BUT NOT USED BY CONSUMER IN THE LAST 3 MONTHS, ANSWER "NO."

		NO	YES
a.	Glasses or other visual aids?	0	1
b.	Helmet?	0	1

8. Please indicate whether consumer has taken any of the following types of prescription medications in the **last 3 months**.

(If do not know medication classifications, simply list all medications taken in the **last 3 months** on the bottom of the page. PLEASE PRINT.)

	NO	YES
a. Antidepressants? (e.g., Lithium, Elavil)	0	1
b. Antipsychotics? (e.g., Thorazine, Mellaril, Haldol)	0	1
c. Antianxiety agents for spasticity or behavior control? (e.g., Librium, Valium)	0	1
d. Anti-seizure medications for seizure or behavioral control? (e.g., Tegretol, Phenobarbital, Dilantin)	0	1

e. If the consumer is taking any of the medication types (a-d) listed above, please indicate date of **last** medication review here

___ ___/ ___ ___/ ___ ___

f. Diabetes medications? (e.g., Insulin)	0	1

If you do not know medication classifications, simply list medications taken in the **last 3 months** here. Dosages and administration times are not needed. PLEASE PRINT.

Thank you for your assistance!