

Vital Signs BP sit _____ BP standing _____		P ___ T ___	Wt. ___ lb	Ht. ___ in
Eyes	<input type="checkbox"/> nl conjunctiva & lids	Feet	<input type="checkbox"/> no deformity, lesions, tenderness	
Pupils	<input type="checkbox"/> pupils symmetrical, reactive	Nails	<input type="checkbox"/> no clubbing, cyanosis	
Fundus	<input type="checkbox"/> nl discs & pos elements	Footwear	<input type="checkbox"/> supportive, safe, well-fitting	
Vision	<input type="checkbox"/> acuity and gross fields intact			
ENT-External	<input type="checkbox"/> no scars, lesions, masses	Neurologic		
Otoscopic	<input type="checkbox"/> nl canals & tympanic membranes	Check nl, circ abn	ROM	Strength
Hearing	<input type="checkbox"/> nl to _____	Upper extrem	<input type="checkbox"/>	<input type="checkbox"/>
Intranasal	<input type="checkbox"/> nl mucosa, septum, turbinate	Lower extrem	<input type="checkbox"/>	<input type="checkbox"/>
Ant. Oral	<input type="checkbox"/> nl lips, teeth, gums			
Oropharynx	<input type="checkbox"/> nl tongue, palate, pharynx			
Neck palp.	<input type="checkbox"/> symmetrical without masses	Mental status	<input type="checkbox"/> nl alertness, attentive	
Thyroid	<input type="checkbox"/> no enlargement or tenderness	Cranial nerves	<input type="checkbox"/> w/o gross deficit	
Resp. effort	<input type="checkbox"/> nl without retractions	Coordination	<input type="checkbox"/> nl rapid alternating movement	
Chest percuss.	<input type="checkbox"/> no dullness or hyperresonance	DTRs	<input type="checkbox"/> symmetrical, ___ (scale: 0-4+)	
Chest palp.	<input type="checkbox"/> no fremitus	Sensation	<input type="checkbox"/> nl touch, proprioception	
Auscultation	<input type="checkbox"/> nl bilateral breath sounds w/o rales	Orientation	<input type="checkbox"/> nl to m/d/day/yr, time	
		Tandem walk	<input type="checkbox"/> able, steady	
		One leg balance	<input type="checkbox"/> 30 sec eyes open	
		Psychiatric		
		Mood	<input type="checkbox"/> nl good eye contact, appropriate	
		Memory	<input type="checkbox"/> nl short term and long term memory	
		Thought process	<input type="checkbox"/> nl no delusions, phobias, hallucinations	
Heart palp.	<input type="checkbox"/> nl location, size	Get up and Go Test (circle abnormal, check normal)		
Cardiac ausc.	<input type="checkbox"/> no murmur, gallop, or rub	Sitting balance	<input type="checkbox"/> steady, safe when upright	
Carotids	<input type="checkbox"/> nl intensity w/o bruit	Arise w/arms folded	<input type="checkbox"/> able	
Pedal pulses	<input type="checkbox"/> nl posterior tibial & dorsalis pedis	Standing balance	<input type="checkbox"/> steady in narrow stance	
		Eyes closed	<input type="checkbox"/> remains steady	
Abdomen	<input type="checkbox"/> no masses or tenderness	Nudge	<input type="checkbox"/> recovers w/o difficulty	
L/S	<input type="checkbox"/> no liver/spleen	Gait initiation	<input type="checkbox"/> no hesitancy	
Hernia	<input type="checkbox"/> no hernia identified	Step length/ht	<input type="checkbox"/> each foot passes stance, clears floor well	
Anus/rectal	<input type="checkbox"/> no abnormality or masses	Step symmetry	<input type="checkbox"/> step lengths equal, regular	
Breasts	<input type="checkbox"/> nl inspection & palpation	Pattern	<input type="checkbox"/> continuous, regular steps	
		Path	<input type="checkbox"/> straight w/o walking aide	
		Stance	<input type="checkbox"/> steps with heels together	
		Sitting	<input type="checkbox"/> safe, smooth, judges distance correctly	
		Speed	<input type="checkbox"/> 10 feet in less than 10 seconds	
Comments:		Gait Description		
		Carotid sinus stimulation (if indicated)		
		Recumbent PreBP ___ P ___ PostBP ___ P ___		

Assessment	
Recommendations	
Environmental changes:	
<p>Assistive device</p> <ul style="list-style-type: none"> <input type="checkbox"/> Straight cane <input type="checkbox"/> Quad cane <input type="checkbox"/> Hemi-walker <input type="checkbox"/> Standard Walker <input type="checkbox"/> Rolling walker <input type="checkbox"/> Three-wheel walker <input type="checkbox"/> Other: 	<p>Exercise program</p>
<p>Referrals</p> <ul style="list-style-type: none"> <input type="checkbox"/> Physical therapist <input type="checkbox"/> Podiatry <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Bone density <input type="checkbox"/> Emergency response <input type="checkbox"/> VNA home safety evaluation 	<p>Educational Materials</p> <ul style="list-style-type: none"> <input type="checkbox"/> Falls: General Information <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Falls Health Care Professionals <input type="checkbox"/> Exercise <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Low Vision <input type="checkbox"/> Footwear <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other: