# Comprehensive SOC Checklist:

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| | Patient Name: Date:<br>MD/DO:<br>Reason for Visit: SOC, ROC, Recert, F/U, DC |
| S | **From:** Community/Hospital/SNF<br>**DC Date:**<br>**LOS:**<br>**Reason for referral (CC):**<br>**PMHx**:<br>**PSHx:**<br>**HPI (OLDCART):**<br><br>Diabetes, PAD, or PVD?<br>**IV Access** Y/N<br>**Oral:** indep/setup/reminder/unable/NA<br>**Injectable:** indep/setup/reminder/unable/NA<br>**Medications (MED LIST)**:<br><br>Drug Issues:<br>**Allergies:**<br><br>**Limitations:** Amputation, Dyspnea, Paralysis, Contracture, Blind, Incontinent, Hearing, Endurance, Speech<br>**Lives:** Alone, w/Someone, ALF<br>**Assistance Available:** Around Clock, Day, Night, Short Term, None ///<br>**PCG** name & contact:<br><br>**Community/Social Screening:** Needs resources, Sadness, Suicidal, Suspected Abuse/Neglect For:<br>**MSW Needed:** Y/N<br>**Home Safety:** Stairs, No running water**;** poor lighting, heat, or cool**;** narrow or obstructed walkways, insects/rodents, no fire safety, cluttered/soiled, Other:<br><br>**O2 Safety** Y/N: NA, No Smoking Signs, Smoke inside, Smoke Detectors, Fire Extinguisher, Safe Cylinder Storage, Cords Intact, Evacuation Plan, Cleaning Fluids, No petroleum products, Only water-based lip moisturizers<br><br>**Pain:**<br>**Code Status:** DNR/Full code<br>**Adv Directives:**<br>**Vaccines:** Flu, Pneumonia, Shingles, TB |

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| O | **VS:** BP: PP: Temp: Resp: O2:<br>Ht:<br>Wt:<br>BS: Labs (if any):<br><br>**HEAD TO TOE ASSESSMENT/REVIEW OF SYSTEMS:**<br>**Sensory:** Eyes/Vision: Poor vision? Y/N Ears: HOH? Y/N Nose: Nasal obstruction? Y/N<br>**Neuro:** Oriented: Person Place Time, Disoriented, Forgetful, PERRL, Seizures, Tremors<br>**Psychosocial:** Poor Environment, Poor Coping, Agitated, Depressed, Impaired Decision-Making, Anxiety, Inappropriate Behavior, Irritability **PHQ-2:** Last two weeks, Little interest or pleasure in doing things? Feeling Down, depressed, or hopeless<br>**Lungs:** SOB, Supplemental O2, O2 Sat, Cough, **Auscultation** lung fields: Adventitious lung sounds? Y/N<br>**Cardiac:** Chest Pain, Dizziness, Edema, Heart Sounds, Peripheral Pulses, Cap Refill <3, >3 Pacemaker. AICD<br>**Bowels:** Incontinen Freq **Ostomy:** **Dialysis** Hemo, Graft/Fistula Site: CVC Site: Peritoneal Signs of infection Y/N<br>**Nutrition:** Dysphagia, Poor Appetite, Wt Loss/Gain: **Diet:** Adequate Y/N **Problems:** Throat, Dental, Dentures, Chewing, Other:<br>**Urinary:** Incontinence, Distention, Burning, Frequency, Dysuria, Retention, Urgency, Urostomy<br>**Catheter** Last Changed: Cloudy, Odorous, Sediment, Hematuria **Genitalia:**<br>**Skin: Wounds:**<br>**Diabetes:** Insulin, pt/cg draw dose/administer, oral hypoglycemic, pt/cg indep with glucometer, inspect feet **Blood Sugar:**<br>**Other Endocrine:** Polyuria, Polydipsia, Polyphagia, Neuropathy, Radiculopathy, Retinopathy // Thyroid Problems:<br>**Musculoskeletal:** WNL Weakness Amb Difficulty Limited Mobility/ROM Joint Pain/Stiffness Poor Balance Grip Strength R L Bed Bound Chair Bound Contracture Paralysis<br>**Has Assistive Device/s:**<br>**Needs DME:**<br>**ADL/IADLs: Activities Permitted:** Bed Rest Cane Partial Weight Bearing Up as tolerated Walker Crutches Exercise Prescribed Wheelchair Indep at Home Transfer bed<>chair Other:<br>**ADLs: Indep/Setup/Assist/Dep/Device** Grooming Dress upper Dress Lower Bathing Toilet Transfer Toilet Hygiene Transfers Amb Eating<br>**GG Scoring**: 6 – Indep 5 – Setup 4 - Sup/touch 3 – Partial/Mod 2 – Substantial/Max 1 – Dep 7 – Refused 9 – NA 10/88 - No attempt enviro/safety<br>**GG Questions:** Self Care Eating Oral Hygiene Shower Self Dress Upper Dress Lower Don/Doff Footwear<br>**Mobility** Roll Sit>Lying Lying>Sit Sit>Stand Chair<>Bed Toilet Transfer Car Transfer Walk 10 50 (+2 turns) 150 Steps 1 4 12 Pick up object WC Assist 50 150 (+2 turns) |
| A | **Nursing Diagnosis:**<br>Possible New Medical Diagnosis (if any):<br>Additional Notes: |
| P | **Nursing Intervention:**<br>**Consents/RS Signed:** Y/N<br>**HHA Agency contact info given:** Y/N<br>**Disciplines Needed:** PT/OT/ST/SN/MSW, Aide<br>**Next Physician Visit:**<br>**Pharmacy name and phone:** |