



Nursing Supervisory Summary for the Dates of _____ To _____

Nursing Agency _____ Nursing Supervisor _____

Child's Name _____ Age _____ Birthdate _____

DSCC# _____ Agency # _____ Nursing Hours per week _____

List of therapies provided _____ Community _____ Home Based _____

Primary Diagnosis _____ Secondary Diagnosis _____

Primary Physician _____

Social Services:

Family issues: (any issues that have transpired during the past month)

Staffing issues from the parents' perspective: _____

Change in family structure: (i.e., parent left the home, death, separation, additional foster placement)

Structural change to dwelling: _____

Loss of gas, electrical or phone service: _____

Sibling issues: _____

Transportation difficulties: _____

Identify any additional agencies working with the child/family: _____

Are there any new trained caregivers? _____

Nursing Services:

Amount of nursing hours prescribed for above time period? _____

Amount of nursing hours provided for above time period? _____

Amount of respite provided for the above time period? _____

Usual days of service Mon Tues Wed Thurs Fri Sat Sun Varies

Usual times of service: A.M. from _____ to _____; P.M. from _____ to _____

Does nurse accompany child to school? Yes No N/A If yes, are nursing services paid by DSCC or the school district? _____ # of days unable to attend school: _____

Please explain any reasons for unfilled shifts: _____

Any changes in insurance benefits: No Yes If so, what has changed? _____

Hospitalizations For Above Time Period:

Date of Admission _____ Date of Discharge _____

Reason _____

(If more than one admission, please list on a separate sheet)

Date of ER visit _____ Reason _____

(If more than one ER visit, please list on a separate sheet)

Last M.D. appointment date _____ With whom _____

Next M.D. appointment date _____ With whom _____

Any appointments missed? _____

Clinical Status: (Please include ventilator parameters; Bipap or CPap; oxygen flow rate or percentage; trach type, size, and care; hyper-al and lipids and central line care.)

Note any clinical, or equipment, or developmental changes during this period: _____

Medications & Dosage:

Diet/Nutrition: (Include route; type; intake and output; restrictions; and tolerance):

Route? _____ Type? _____ Usual intake per feeding? _____

Appetite? _____ Tolerance? _____ Ht. _____ Wt. _____

Is there a physician's order? _____ Within last 6 months? _____

Is child followed by a nutritionist? _____

Describe Most Recent Supervisory Visit (date, who was there, issues discussed, when case conference was held, when next one is scheduled):

Goals/Plan/Recommendations:

Nursing Supervisor Signature

Date