Rhode Island Department of Social and Rehabilitative Services  
Nursing and Intermediate Care Unit  
Social Worker's Evaluation of need for Care in  
A Nursing or Intermediate Care Facility

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

### A. PRESENT SITUATION

1. **New Referral**  
   If in Hospital, Name of Referring Person  
   Explain how Client's needs have been met up to now and if consideration has been given to helping the Client remain at Home or to placement with Relatives, etc.

2. **Re-Evaluation**  
   Date of Last Authorization __________________________ for __________________________  
   Indicate: (A) Length of stay in this home. (B) Attitude towards home. (C) Motivation towards rehabilitation  
   (D) Other pertinent data.

### B. PHYSICAL AND MENTAL STATUS AND FUNCTIONAL CAPACITIES (Place check (✓) in appropriate spaces)

1. **AMBULATION**  
   - alone
   - with cane
   - with crutches
   - with walker
   - with personal assistance
   - bed to chair only
   - bedridden

2. **BODY HYGIENE**  
   - tends to toilet functions alone
   - tends to toilet functions with help
   - occasionally incontinent. bowel ( ) bladder ( )
   - moderately incontinent. bowel ( ) bladder ( )
   - chronically incontinent. bowel ( ) bladder ( )

3. **PERSONAL REQUIREMENTS**  
   - needs little or no help
   - needs help bathing
   - needs help dressing
   - needs help feeding

4. **MENTAL AND EMOTIONAL NEEDS**  
   - Alert
   - Disoriented
   - Forgetful
   - Confused
   - Belligerent
   - Withdrawn

5. **SENSES**  
   - normal sight
   - failing sight
   - partially blind
   - blind
   - normal hearing
   - impaired hearing
   - partially deaf
   - deaf

6. **OTHER IMPAIRMENTS (SPECIFY)**  

---

Date: ________________________  
Sex: ________________________  
Date of Birth: ________________________  
Case Number: ________________________  
If Hospitalized, Name of Hospital: ________________________  
Date of Admission: ________________________  
Address or Name of Facility and Classification: ________________________
C. **SERVICES REQUIRED**

(Note: If New Case, Indicate whatever information is known to you
If Re-Evaluation, Give Name and position of person in NIC home who is helping to provide this information)

Name of person giving information
Position in NIC home.

______Requires only general supervision, incidental medications, enemas, etc.
______Requires the following services as checked:

( ) Dressings
( ) Catheter Irrigations
( ) Attention to colostomy by home staff
( ) Medications by Injection
( ) Extensive Oral Medications
( ) Physiotherapy
( ) Oxygen Administration
( ) Intravenous of Tube Feedings
( ) Other (Specify):

D. What attempts have been made to keep the patient in the community, through the use of community resources?

E. General description of patient's condition and services that must be performed for the patient and what the patient can do for himself or herself:

Caseworker's Signature