

Child's Name: \_\_\_\_\_  
Nursing Supervisory Summary for the Dates of \_\_\_\_\_ To: \_\_\_\_\_

Nursing Agency \_\_\_\_\_ Nursing Supervisor \_\_\_\_\_

Child's Age \_\_\_\_\_ Birthdate \_\_\_\_\_ DSCC# \_\_\_\_\_

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 60 days)  
\_\_\_\_\_  
\_\_\_\_\_
- 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: \_\_\_\_\_
  - If so, what action was taken: \_\_\_\_\_
- Sibling issues: \_\_\_\_\_
- Transportation difficulties: \_\_\_\_\_
- Identify any additional agencies working with the child/family: \_\_\_\_\_  
\_\_\_\_\_
- Are there any changes in current list of trained caregivers? \_\_\_\_\_

**Nursing Services:**

- Amount of nursing hours/week prescribed for above time period? \_\_\_\_\_
- Average amount of nursing hours provided per week 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: \_\_\_\_\_  
\_\_\_\_\_

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- Any changes in insurance benefits:  No  Yes If so, what has changed? \_\_\_\_\_

**Hospitalizations For Above Time Period:** *(If more than one admission/ER visit, please list on a separate sheet)*

- Date of Admission \_\_\_\_\_ Date of Discharge \_\_\_\_\_  
Reason \_\_\_\_\_

- Date of ER visit \_\_\_\_\_ Reason \_\_\_\_\_

- Last M.D. appointment date \_\_\_\_\_ With whom \_\_\_\_\_

- Next M.D. appointment date \_\_\_\_\_ With whom \_\_\_\_\_

- Any appointments missed? \_\_\_\_\_

**Clinical Status:** (Indicate child's status and changes over the past 60 days include ventilator parameters; use of Bipap or CPap; oxygen flow rate or percentage changes; hyper-al and lipids or central line changes.)

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**Note any developmental or educational changes over the past 60 days:** \_\_\_\_\_

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**Head to Toe Assessment:** (May use agency assessment document and attach.)

**Respiratory:** \_\_\_\_\_

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**Cardiovascular:** \_\_\_\_\_

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**Musculoskeletal:** \_\_\_\_\_

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**Gastrointestinal/Genitourinary:** \_\_\_\_\_

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**Neurological:** \_\_\_\_\_  
\_\_\_\_\_

**Skin Integrity:** \_\_\_\_\_  
\_\_\_\_\_

**Medications & Dosage:** Indicate any changes in the medications over the past 60 days.  
\_\_\_\_\_  
\_\_\_\_\_

**Diet/Nutrition:** (Include route; type; intake and output; restrictions; and tolerance):  
Route/s? \_\_\_\_\_ Type of tube? \_\_\_\_\_ Appetite and tolerance? \_\_\_\_\_

Diet: \_\_\_\_\_

Is child followed by a nutritionist? \_\_\_\_\_

Reflux? \_\_\_\_\_ If yes, what aspiration precautions are taken? \_\_\_\_\_

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

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

Date: \_\_\_\_\_

Who attended: \_\_\_\_\_  
\_\_\_\_\_

**Discussed:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Unable to do home visit at scheduled time because:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Attach a copy of the current Plan of Care**

\_\_\_\_\_  
Nursing Supervisor Signature

\_\_\_\_\_  
Date