COUNTY OF LOS ANGELES
Public Health

PHN Assessment Tool

Every attempt must be made to complete a home visit on every referral in order to do a complete assessment!!

Demographics

Public Health Nursing Practice Manual

PHN ASSESSMENT FORM

Date Form Initiated ______________ SPA ____ District __________ Program _____ CT__________
Client's Last/First Name ________________ AKA Last/First Name ______________________
Telephone ______________________ ☐ Home ☐ Work ☐ Other ______________
Address ______________________ City ______________________ Zip _______
Ethnicity/Race ______________________ Language ______________________
Source of Referral: ☐ Disease Control ☐ Health Line ☐ Other ______________
Referral Type ☐ ACD _____ ☐ TB ______ ☐ STD _____ ☐ OB-HCF _______ ☐ OB-GENL ________
☐ LEAD____ ☐ SIDS ☐ ABUSE ☐ OTHER ______________

1. Answer questions as presented.
2. Source of Referral: Where did referral come from? Disease control or other?
3. Referral Type: Select appropriate type.

Assessment

PHN ASSESSMENT

Family Member	Primary Care Health Coverage	Family Violence	Safety	Immunization	Healthy Habits
#_____ ☐ Declined ________________ DOB ____________ ☐ self ☐ other _____ ☐ Male ☐ Female ☐ Other ☐ Pregnant EDD ______ ☐ Diabetic ☐ Asthma ☐ Mental Health Concern Date ______________	Primary Provider ☐ No ☐ Yes Health Coverage ☐ No ☐ Yes Type ________ Needs Dental Care? ☐ No ☐ Yes ☐ Declined	☐ No ☐ Yes ☐ Susp ☐ Declined	Hazard ☐ None ☐ Yes _______ _______ _______ _______ ☐ Declined	Up-to-date ☐ No ☐ Yes ☐ Unsure ______ ☐ verified ☐ by history ☐ Declined	Healthy diet? ☐ No ☐ Yes Exercises? ☐ No ☐ Yes ☐ NA Smokes/Chem Dependency? ☐ No ☐ Yes ☐ NA Safer Sex Practices? ☐ No ☐ Yes ☐ NA ☐ Declined

1. Family member #1 will always be the referred client.
2. Each "**family member**" must be assessed even if family member is absent.
3. Individuals have the "right" **to decline** parts of, or the entire assessment interview.
4. Check appropriate boxes regarding client's medical history.
5. Family violence: Ask any client 12 years or older if they are concerned about family violence.
6. If PHN sees or suspects abuse, they are required to make a mandated written suspicious injury report to local police.
7. Healthy Habits: May assess children age 11 years or under according to his/her judgment.

Plan

Encounter (circle) 1 2 3 4 date ___ ☐ Home ☐ Office ☐ Telephone ☐ Other

PLAN
Health Need/Goal: ______________________________
Health Need/Goal: ______________________________
Health Need/Goal: ______________________________
Health Need/Goal: ______________________________

1. Encounters: Any visit that relates to follow up of a health need/goal not related to the original referral is considered an encounter.
2. Only 4 encounters per form. If more encounters are needed, a chart must be opened.
3. Plan**:** Each problem identified in the assessment must have a health need/goal listed.
4. Needs may be identified by the PHN or client.

Action/Intervention

ACTION/INTERVENTION given:

☐ Breastfeeding	☐ Day Care	☐ Family Planning	☐ Parenting Class	☐ Safer Sex Practice
☐ Building & Safety	☐ DCFS	☐ Food	☐ PCG	☐ Shelter/Housing
☐ CCS	☐ Dental Care	☐ Immunization	☐ Ped. Primary Care	☐ Smoking Cessation
☐ CHDP	☐ DPSS	☐ Legal Aid	☐ Physical Activity	☐ Transportation
☐ Clothing	☐ Drug/ETOH Tx	☐ NFP	☐ Prenatal Care	☐ Vision Care
☐ Comm. Disease	☐ Environ. Health	☐ Nutrition Counseling	☐ Regional Center	☐ WIC

☐ Counseling/Mental Health referral: ______________________________
☐ Family Violence referral: ______________________________
☐ Healthy Families worker at ________________ ☐ Medi-Cal worker at __________
☐ Medical Care at ________________ ☐ Public Health Clinic at ___________
☐ Other ______________________________

Anticipatory Guidance Given About:

☐ Back to Sleep	☐ Bottle Caries	☐ Physical Activity	☐ Folic Acid	☐ Nutrition Counseling
☐ Immunization ☐ Other	☐ Pre-Conception Counseling	☐ Safer Sex Practices	☐ Safety/Injury Prevention	☐ Smoking/Chem. Dep.

Nutrition/ Physical Activity Counseling/Referral:
Time:_______
Comments ______________________________

1. For each health need/goal, check off the action/intervention given or where client referred.
2. Anticipatory Guide: Check off any anticipatory guidance that the PHN gave the client.
   a. Use this section to document advice that the PHN gave ***not related to a health need/goal identified in the assessment.***

Disposition

DISPOSITION
☐ On-going Level 1 intervention; next contact (date/purpose) ______________________
☐ Close--Level 1
☐ Level 2 intervention needed; next contact (date/purpose) ______________________
☐ Close ☐ Individual/Family declines further service ☐ UTL ☐ other reason ______________
☐ Close ☐ moved within LA County jurisdiction (complete transfer section below) ☐ moved outside LA County jurisdiction
☐ Transfer to ______________________________
Client Satisfaction form given: ☐ yes ☐ no

1. If the client requires more than four (4) encounters to assist with the identified health goal/needs, close Level 2 in NPMS and enter the date and purpose of the next encounter in the text box.
2. Open a medical record if applicable; print a copy of the PHN assessment and place the assessment in the miscellaneous section of the chart. Continue to document in the medical record progress notes.

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