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

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

**Demographics**

**Action/Intervention**

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.

**Assessment**

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.

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.

**Plan**

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.