Connecticut Department of Children and Families
CONGREGATE CARE QUARTERLY NURSING ASSESSMENT
DCF-2270
2/19 (Rev.)

Last Name:	First Name:	DOB:	Age:	Gender: Select One
LINK#:	Allergies:			Review Dates:
DCF Social Worker Name:		DCF Office: Please Select DCF Office		
DCF SWS Name:		RRG Nurse Name:		

Health Alert: ☐ Yes ☐ No. If 'yes" please describe the Health Alert:

Medical Diagnosis:

DSM Diagnosis:

Past Medical History:

Last Name:	First Name:	DOB:	Review Dates:

Immunization Record: ☐ Yes ☐ No. If "yes", please attach.

Current Medications: (Drug / Dose / Route / Time / Last Dose / Target Symptoms):

Medication Changes: (Date / Drug / Dose / Routes / Time / Reason / Adverse Reaction / No Effect)

DOCTORS / PROCEDURES / SURGERY / HOSPITALIZATION

Name of Primary Care Doctor or Specialist	E-mail:		Telephone:
Address:	City:	State:	Zip:

Date of last Visit / Reason / Outcome / Follow-up Appointment:

Psychiatric Consultations ☐ Refer to Psychiatric Med Follow-up Notes ☐ Significant Events, please list below

Name of Psychiatrist	E-mail:		Telephone:
Address:	City:	State:	Zip:

Significant Events:

Last Name:	First Name:	DOB:	Review Dates:

Name of Dentist	E-mail:		Telephone:
Address:	City:	State:	Zip:

Date of last Dental Exam / Reason / Outcome / .Follow-up Appointment:

Name of Eye Doctor:	E-mail:		Telephone:
Address:	City:	State:	Zip:

Date of last Vision Exam /.Follow-up Appointment:

IMMUNIZATION:	AIMS:	EKG:	LABS:	OTHER:	WNL	Problem
Please Select One	Date: Results:	Date Results:	Date: Results:	Sleep: Elimination: ADL: Other:	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

NUTRITION:	EXERCISE:	ADAPTIVE EQUIPMENT:
☐ Regular ☐ Adjustment (Please list below)	☐ Unrestricted ☐ Recommendations (Please list below)	☐ None ☐ Type (Please list below)

Height:	Weight:	*Weight Changes	BMI/BMI %	BP:	P:	R:	Pain Scale: (0-10)

Planning Implementation (Initiation and Revision of Nursing Care Plan):

Was EDUCATION provided to parent or guardian during this quarter? Yes ☐ No ☐ If "yes" please provide details:

Last Name:	First Name:	DOB:	Review Dates:

Evaluation (Nursing Summary):

Name of RN Completing Assessment	Signature of RN Completing Assessment:	Date: