IMLS Nurses Worksheet

Persons Name: _____ **DOB:** ___/___/_____ **Date:** _____

Nurse Name: _____ **Nurse Phone:** (___) - _____- _____

Agency: _____ **Agency Phone:** (___) - _____- _____

Section	Score 1 through 4	Title of Supporting Documentation
A. Medication Administration • Do not count: Home Health, Hospice, Dr. Office, Clinic, etc. • Do not count Tube feeding & respiratory treatments in this section		

B. Medical Care and Supervision
• Hospitalization past year
• Medical Care Contacts past year
  ○ PCP or specialists contacts resulting in change
  ○ ER/Urgent Care visits w no hospitalization
  ○ Diagnostic, Lab, radiological Procedures, swallow studies, etc.		

C. Feeding and Nutrition
• Nutritional Therapy & Fluid Balance
  ○ Oral eaters
  ○ Special Dietary Needs, i.e., I O, wt./measure foods
• Tube Feeding		

D. Respiratory • Aspiration Risk • Ventilator/ C-PAP/B-PAP • Oxygen • Suctioning • Respiratory Therapy/Respiratory Hygiene		
E. Neurological • Seizures • Spasticity • Implantable Devices		
F. Skin Care Assessment & Treatment • Preventive, Wound and Dressing Management		
G. Other Complex Medical Needs • Diabetes • Renal/Bladder • Additional Direct Nursing Needs		
Add all Section scores to get Total Score:		

Current eCHAT Acuity: Low ☐ Moderate ☐ High ☐

☐ Long Term IMLS ☐ Short Term IMLS (Note: Short Term Stay – up to ninety (90) days)