IMLS Nurses Worksheet

Client 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 90 days)

Submit