

EVOLVE FNC Review Tool

Name of the Person	
DOB	
Gender	
DOA	
NHS Number	
GP – Name and Address	
Name and Address of Nursing Home [inc. telephone number, email address]	

Referrals made or involvement from other services – shade as appropriate and date							
GP	Tissue Viability	Lower Limb [inc podiatry]	Wet Leg Team	SALT	Falls Team	Dietician	Bladder & Bowel
Urology	Memory Clinic	Mental Health	Diabetes	Parkinsons Team	Any other specialist services:		

Medical History:	
Medication Prescribed: [inc. PRN prescriptions]	
Amy medication requested by the GP: Emollient and Barrier Cream	Last Acute Admission:

High Level Overview of nursing Needs							
Catheter in place	Ostomy in place	PEG in place	MUST Score >	Waterlow Score >	Falls Risk >	PRN Medication that requires Clinical Oversight owing to increase in risk [add detail below]	
Pressure Damage G1	Pressure Damage G2	Pressure Damage G3	Pressure Damage G4 +	SDTI	Skin Tears/Lacerations/Hematoma	Leg Ulcers	Constipation Concerns
DVT Risk – Active	Blood Pressure Concerns –active nursing oversight	Bilateral leg oedema	Diabetes – unstable and/or complex	COPD active nursing oversight required	Epilepsy	<i>Any other areas where Nursing Oversight is required:</i>	
Baseline Information							
NEWS Score [add detail]			Scale 2 Sign Off [range and date] N/A			Baseline PAINAD [add detail]	
MUST Score			BMI Score			Waterlow Score	
DNACPR in place			Yes			No	
For Hospital Admission [as per TEP or ACP]			Yes		Maybe for symptom control		No

Does the person have capacity?	
Date the GP last contacted	
Reviewer	
Designation	
Date review sent to the home	

Potential Eligibility for CHC funding based on this review [shade as appropriate]	Yes	No
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Part 2 FNC Assessment and Summary**1. Breathing****2. Nutrition Care Domain****3. Continence Care Domain****4. Skin Integrity****5. Mobility – this needs to include fall history****6. Communication – this is to include sensory impairment****7. Psychological and Emotional Well Being****8. Cognition****9. Behaviour****10. Medication [to include date of last medication review with the GP/Pharmacist]****11. Pain Management****12. Any Other Areas of Need Identified**

Name of Practitioner Completing FNC Review	
Designation	
Date	

DO NOT COPY