



**Assigned Task Condition Assessment Form**

DATE OF REQUEST: \_\_\_\_\_ CLIENT: \_\_\_\_\_ PHIN: \_\_\_\_\_  
 Case Coordinator: \_\_\_\_\_ Resource Coordinator: \_\_\_\_\_

**Task: Ear Drops (client specific)**

<b>Conditions of Assignment</b>			
	Yes	No	N/A
Current prescriber order in chart.			
Task has been established as routine and is performed as part of daily care.			
Client assessed and unable to perform the task with or without teaching. (Direct Service Nurse/Case Coordinator)			
Family/Primary Caregiver assessed and not available/unable to perform the task with or without teaching.			
Medication regularly scheduled (no 'as needed' orders).			
Client assessed and unable to perform task with assistive device. (Direct Service Nurse/Case Coordinator)			
Client's condition is stable. (Direct Service Nurse/Case Coordinator)			
Client's response to the proposed task or procedure is predictable.			
Client aware of when to seek assistance, treatment duration greater than 10 days.			

**Client Specific Comments:**

---



---

**Client meets criteria for Assignment of Task to Unregulated Health Care Provider** \_\_\_ Yes \_\_\_ No

**If client meets ALL criteria:**

\*\*Client specific training is required

Assignment Task Plan Completed (This will include the Procedure/Problems to watch for and Client Specific Comments/Teaching written by Nurse):

Yes                      No                      N/A

Medication Reconciliation completed:

Yes                  No                  N/A

Medication Assignment Record – Home Care Attendant completed with medication and assist times; submit to Case Coordinator and Resource Coordinator.

Yes                  No                  N/A

Frequency of Task Monitoring:

Annually with medication reconciliation

Other than Annually – specify frequency:

\_\_\_\_\_

**Assessed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Direct Service Nurse forwards completed document to client’s Case Coordinator.**