

Assigned Task Condition Assessment Form

DATE OF REQUEST: _____ CLIENT: _____ PHIN: _____

Case Coordinator: _____ Resource Coordinator: _____

Task: Oral Medication Setup

Conditions of Assignment								
	Yes	No	N/A					
Current prescribers order in chart.								
Task 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.								
Pharmacy prepared dosing: compliance packaging (e.g. bubble pack), strip								
packaging, oral syringes. Solid dose formulation, liquid preparations,								
altered dose i.e. crushed medications. Includes opioids if client stable.								
Client with swallowing disorder: refer to Swallowing guideline.								
Client is not cognitively impaired.								
Client/Primary Caregiver understand the risk with a medication setup.								
(Direct Service Nurse/Case Coordinator)								

Client Specific Comments:

Client meets criteria for Assignment of Task to Unregulated Health Care Provider ____ Yes ____ No

If client meets ALL criteria:

Is client specific training required:

Yes No 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.