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MONTHLY SKIN CHECK

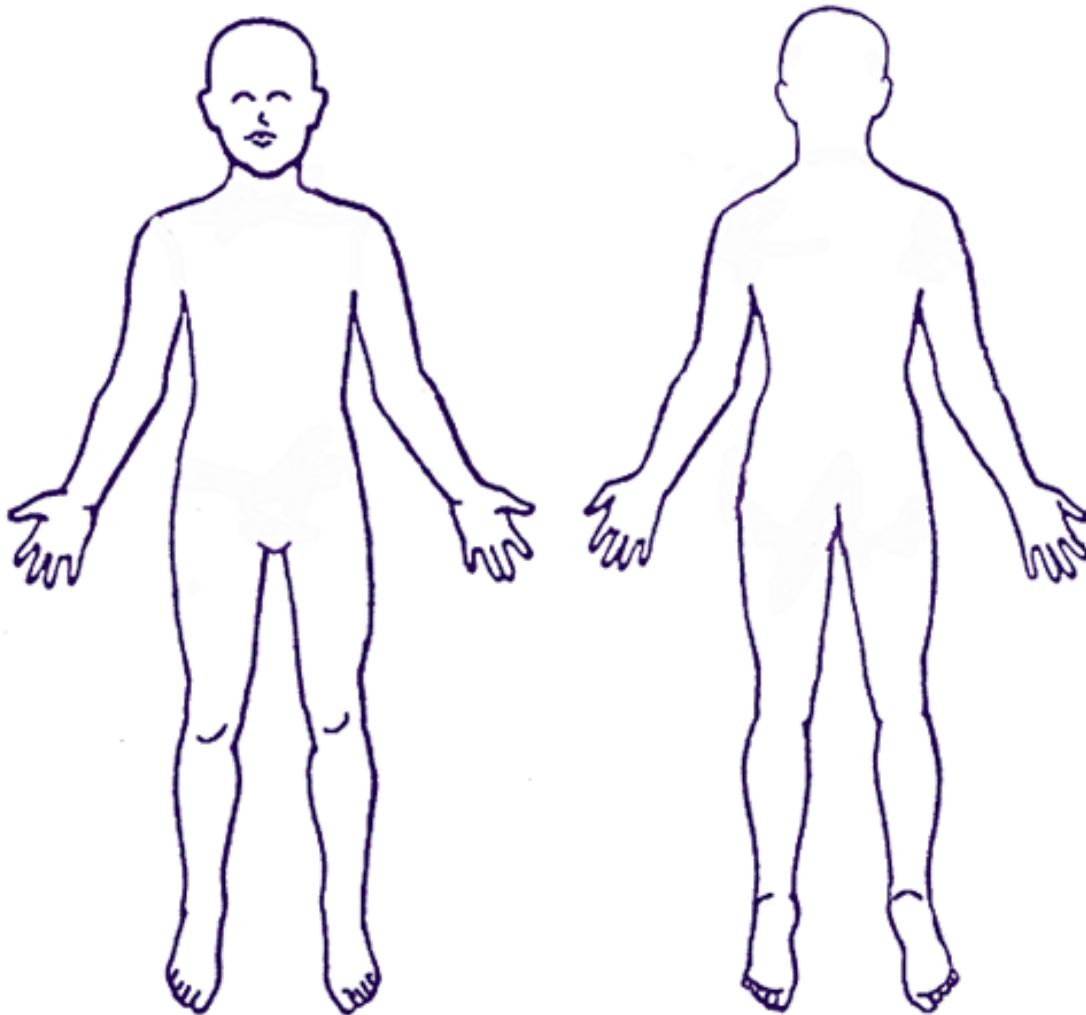
Consumer Name: _____

Date: _____

Nursing Agency: _____

Fax: _____

Please examine the Consumer's skin thoroughly and note any concerns (i.e. skin breakdown, abnormal growth, etc.) at the corresponding point on the diagram below. Send the completed skin check to your CDPC support coordinator by mail or fax.



No skin issues

Print ACW Name: _____

ACW Signature: _____

Support Coordinator: Fax this form to the above named nursing agency and the case manager.