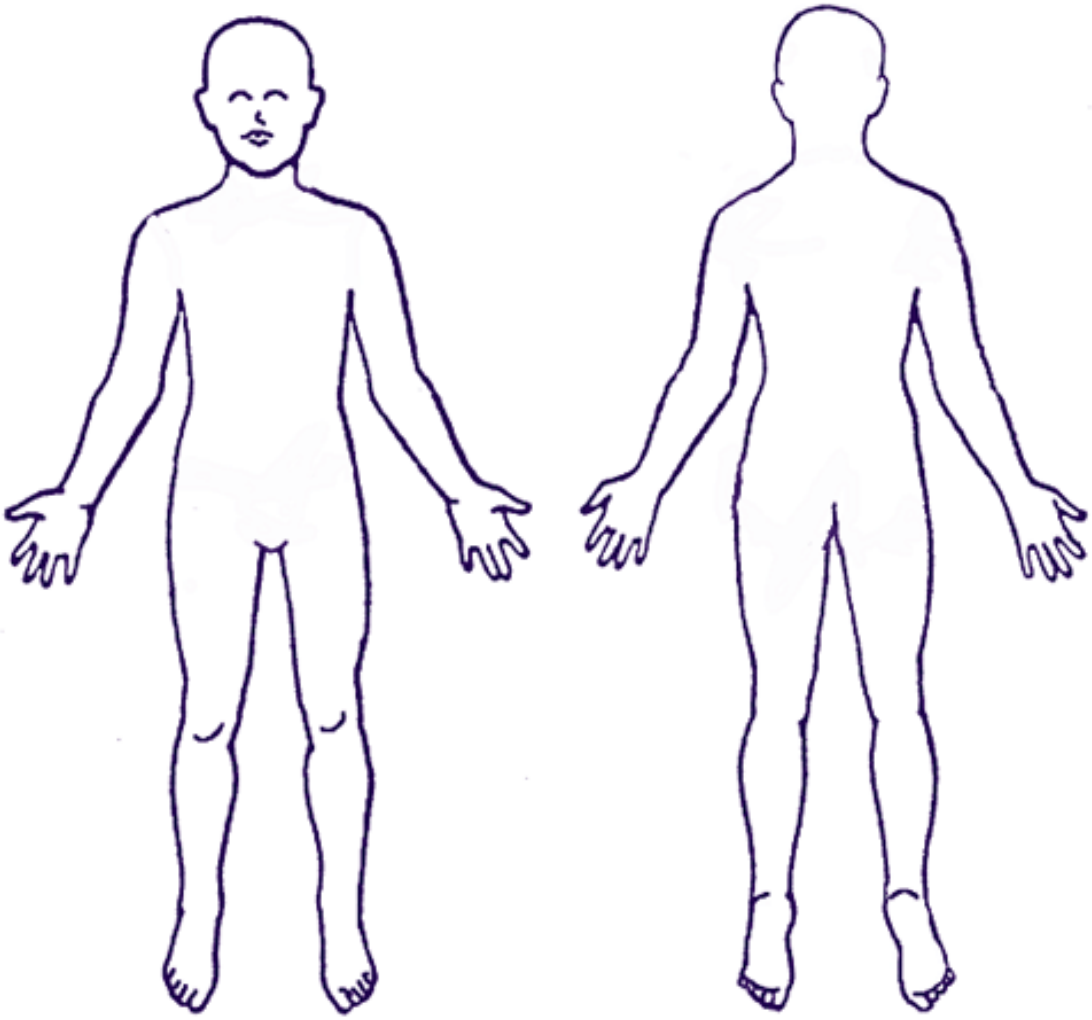
CONSUMER DIRECT CARE NETWORK ARIZONA

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 Consumer Direct Care Network support coordinator by mail or fax.



□ No skin issues

Print ACW Name: _____ ACW Signature: _____

Support Coordinator: Fax this form to the above