ADMISSION ASSESSMENT *see narrative notes

DATE/TIME:

MODE: ☐ Ambulatory ☐ Carried ☐ Stretcher ☐ W/C ☐ Ambulance

ADMITTED FROM: ☐ ER ☐ Home ☐ M.D Office ☐ Other Hospital ☐ Nursing Home ☐ MRSA/VRE Protocol ACCOMPANIED BY:

Admitting Diagnosis:

Procedure:

NPO SINCE: | HGB OR HCT:

ALLERGIES (Drug, tape, soap, food) | Reaction(s) | ☐ NKA

Allergies	Reaction(s)

Armband Applied ☐ | Latex Allergy ☐ Yes ☐ NO

Immunizations Current ☐ Yes ☐ No

Advance Directive: ☐ Y ☐ N ☐ N/A ☐ Info Given

- ☐ None
- ☐ Hearing Aid
- ☐ Glasses/Contacts
- ☐ Watch
- ☐ Dental Appliance
- ☐ Jewelry
- ☐ Sent with family
- ☐ Other:

Valuables:

DATE	TIME	TEMP	PULSE	RESP	B/P	ADM	DATE	TIME	TEMP	PULSE	RESP	B/P	WT.	HT.	OTHER

MEDICATIONS: (includes OTC Drugs) CODES A - sent home with family B - may be self administered C - meds stored in pharmacy D - not brought to hospital

NAME & DOSE ☐ SEE ATTACHED LIST	TIME	LAST DOSE	CODE

FAMILY HISTORY DISEASE OF ☐ HEART ☐ DIABETES ☐ LUNG ☐ CANCER ☐ MENTAL ☐ STROKE ☐ OTHER ☐ UNREMARKABLE

PAST MEDICAL HISTORY ☐ UNREMARKABLE

Liver Problems/Hepatitis	☐	Kidney Problems	☐
Heart Problems	☐	Lung Problems	☐
Hypertension	☐	Glaucoma	☐
Strokes/Seizure	☐	Cancer	☐
Pacemaker	☐	Alcohol/Substance Abuse Tobacco	☐ ☐
Bleeding Disorders	☐	Mental Illness	☐
Diabetes		Amputee	☐
TYPE 1 Insulin dependent TYPE 2	☐ ☐	Pregnancy Possible LMP	☐

Other Medical Problems /Surgeries /Anesthesia Complications:

ER Only: Time:

TETANUS: UTD ☐ Yes ☐ No

Persons Notified
Relative ______ TIME ______ BY ______
Police ______ TIME ______ BY ______
Coroner ______ TIME ______ BY ______

Discharge Instructions Given
☐ Medical ☐ OB Gyn
☐ Trauma ☐ Pediatric
☐ Delivered Verbally

Disposition
☐ Admitted ☐ Ambulatory ☐ W/C
Room ______ ☐ Ambulance ☐ Carried
☐ Discharged ☐ LWBS ☐ Stretcher
☐ Expired in ER ☐ AMA

Discharge Nurse ______ Time ______

PHYSICAL ASSESSMENT:

ORIENTED: ☐ Person ☐ Place ☐ Time ☐ Situation

LOC: ☐ Alert ☐ Confused ☐ Comatose ☐ Drowsy ☐ Sedated ☐ Semicomatose

EYES: ☐ No Problems ☐ Blind ☐ Drainage ☐ Jaundiced ☐ Cataracts
PERRL ☐ Lt. ☐ Rt.

EARS: ☐ No problems ☐ HOH ☐ Drainage ☐ Hearing Impaired

MOUTH: ☐ Dry ☐ Moist
TEETH: ☐ Good Repair ☐ Poor Repair ☐ Odor ☐ Edentulous

SPEECH: ☐ Aphasic ☐ Slurred ☐ Clear

SKIN: ☐ Cool ☐ Warm ☐ Diaphoretic ☐ Dry ☐ Cyanotic ☐ Dusky
☐ Fragile ☐ Jaundice ☐ Mottled ☐ Pale ☐ Pink
Turgor: ☐ Good ☐ Poor
☐ Other ______

RESPIRATORY/CARDIOVASCULAR:

☐ Clear/Nonlabored ☐ HR Regular ☐ Irregular ☐ Gallop
☐ Crackles ☐ Diminished ☐ Murmur ☐ Wheezes ☐ Cough
☐ O_2 ______ ☐ S_1 S_2 ☐ Cardiac Monitor ______

PERIPHERAL PULSES: ☐ Strong ☐ Weak ☐ Absent ______
☐ Other ______

EDEMA: ______

GASTROINTESTINAL:ABDOMEN ☐ Soft ☐ Flat ☐ Distended

Last BM ______

BOWEL SOUNDS: ☐ Active ☐ Hypoactive ☐ Absent
☐ Other:

GENITOURINARY

☐ Normal ☐ Frequency ☐ Discharge
☐ Burning ☐ Hematuria ☐ Dysuria
☐ Nocturia ☐ Odor ☐ Incontinence
☐ Diff. Starting Stream ☐ Foley Catheter
☐ Other:

MUSCULOSKELETAL:

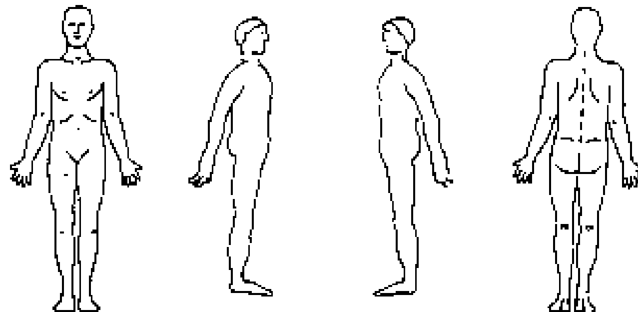
☐ Paralysis ______
☐ Amputations ______
☐ Arthritis ______
☐ Atropiny ______
☐ Contractures ______
☐ Fractures ______
☐ Numbness ______
☐ Pain ______
☐ Tremors ______
☐ Evidence of neglect/injury ______

EXTREMITY MOVEMENT: ☐ Normal ☐ Limited ____ RA ____ LA
____ RL ____ LL

PAIN HISTORY:

Have pain routinely? ☐ Yes ☐ No ☐ Occasional
How Severe ? (score 0-6) ______
What relieves the pain? ______

If you had serious illness or surgery in the past, what pain measures were helpful? ______



A - Dialysis Access D - Decubitus I - Incision L - Laceration R - Rash
B - Burn E - Erythema IM - Implant P - Petechiae S - Scar
C - Contusion F - Pacemaker IV - ______ OTHER ______

STAGE 1 - Reddened Area ______ cm
STAGE II - Blistered/Break ______ cm
STAGE III - Subc. Exposure ______ cm
STAGE IV - Muscle /Bone Exposure ______ cm

Comments:

PSYCHOSOCIAL ASSESSMENT

EMOTIONAL STATUS: ☐ Anxious ☐ Depressed ☐ Cooperative
MARITAL STATUS: ☐ Married ☐ Widowed ☐ Divorced ☐ Single
OCCUPATION: ☐ Retired ☐ Employed ☐ Disabled ______
LIVES WITH: ☐ Self ☐ Spouse ☐ Family ☐ Nursing Home ☐ Other
NAME: ______
ADL PERFORMED BY: ☐ Self ☐ Family W/Assist ______
ACTIVITY LEVEL: ☐ AMB ☐ W/C ☐ Cane ☐ Bedrest ☐ Walker
CURRENT USE OF MED. EQUIP. IN HOME ☐ N ☐ Y (list) ______

CURRENT HOME HEALTH AGENCY ______ ☐ N/A
WILL THIS HOSPITALIZATION CAUSE PROBLEMS WITH:
☐ Child Care ☐ Cultural Practices ☐ Religious Practices ☐ Home Life ☐ Finances
ROOM ORIENTATION: Provided to: ______
☐ Bed ☐ Bathroom ☐ SRMC Complaint Procedure ☐ Telephone
☐ Call Light ☐ No smoking policy ☐ Unit Managers Name

NUTRITION ASSESSMENT

Typical Daily Food Pattern: ______
Food Intolerances: ______

Unplanned Loss (within last month)	5-10 lbs	= 1
	10-20 lbs	= 2
	> 25 lbs	= 3
50% Reduction of dietary intake for 5-7 days		= 1
Difficulty Chewing/Swallowing		= 1
Nausea/Vomiting		= 1
Diarrhea/Constipation		= 1
Decubitus III, IV		= 3
TOTAL POINTS		=

If a score of 3 is identified, a nutrition consult is indicated.

Dietitian consulted ☐

THIS FORM INITATED BY: (SIGNATURE/TITLE)

Input From Significant Other:

EDUCATIONAL ASSESSMENT

Communication Deficit (i.e. aphasia/dysphasia) ☐ Yes ☐ No
Physical Disability/Impairments ☐ Yes ☐ No
Language: ☐ English Other Interpreter
Emotional Barriers: (i.e. fear anxiety) ☐ Yes ☐ No
Literate: ☐ Yes ☐ No
Motivated to learn/Readiness Level: ☐ Yes ☐ No
Cultural/Religious practices which may impact learning: ☐ Yes ☐ No
Other:
Learner learns best by: ☐ Verbal Instruction ☐ Audiovisual Instruction ☐ Written Instruction ☐ All
Learners: Patient Family (names/relationships)

Academic Needs ☐ Yes ☐ Educational Coordinator Notified

LEARNING NEEDS

TEACHING NEEDS IDENTIFIED:
Basic Hygiene: Yes ☐ Specify
PERCEIVED EDUCATIONAL NEEDS: Do you or your family need information on the following?
☐ Diagnosis/Illness ☐ Medications ☐ Diet ☐ Activity ☐ Equipment ☐ Home Care ☐ Community Resources
Financial implications of care choices: Need assistance ☐ No ☐ Yes
Other:

Educational packet given ☐ Yes ☐ N/A

DISCHARGE PLANNING:

☐ No needs anticipated
☐ Anticipate minor changes
☐ Major changes
☐ Rehab placement
☐ Nursing Home

☐ Home Health
☐ Social Services
☐ Referrals
☐ Transportation
☐ Dietary

☐ Equipment
☐ Home
☐ With family
☐ Other

NARRATIVE NOTES

SIGNATURE/TITLE/DEPT	DATE/INIT	SIGNATURE/TITLE/DEPT.	DATE/INIT

The Morse Fall Scale

					SCORE
1.	History of Falling	☐ No = 0	☐ Yes = 25		______
2.	Secondary Diagnosis	☐ No = 0	☐ Yes = 15		______
3.	Ambulatory Aid	☐ None/bedrest/nurse assist = 0	☐ Crutches/cane/walker = 15	☐ Furniture = 30	______
4.	Intravenous Therapy-Heparin Lock	☐ No = 0	☐ Yes = 20		______
5.	Gait	☐ Normal/bedrest/wheelchair = 0	☐ Weak = 10	☐ Impaired = 20	______
6.	Mental Status	☐ Oriented to own ability = 0	☐ Overestimates/forgets limitations = 15		______

A score of > 45 identifies a patient at high risk for falling. **Total** ______

BRADEN RISK ASSESSMENT SCALE

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited:** Unresponsive (does not moan, flinch or grasp to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface).	**2. Very Limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment:** Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.	SCORE
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist:** Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	**2. Very Moist:** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist:** Skin is usually dry, linen only requires changing at routine intervals.	SCORE
ACTIVITY degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast:** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	SCORE
MOBILITY ability to control change and control body position	**1. Completely Immobile:** Does not make even slight changes in body or extremity position but unable to make frequent or significant changes independently.	**2. Very Limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited:** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitations:** Makes major and frequent changes in position without assistance.	SCORE
NUTRITION usual food intake pattern	**1. Very Poor:** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. Or is NPO and or maintained on clear liquids or IV's for more than 5 days.	**2. Probably Inadequate:** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein(meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regime which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat or dairy products. Occasionally eats between meals. Does not require supplementation.	SCORE
FRICTION AND SHEAR	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction.	**2. Potential Problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		SCORE

Note: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers. (15 or 16=low risk, 13 or 14=moderate risk, 12 or less=high risk.) TOTAL SCORE ______

For patients with a score of 16 or less, write a "potential for skin impairment" nursing diagnosis on the problem list.