Date _____ **Time** _____ HEIGHT: _____ WEIGHT: _____

Reason for admission (patient's own words) _____

Admitted from: ❒ Home ❒ Physician office ❒ ER ❒ Other Facility name _____

Person providing information: ❒ Patient ❒ Other (name) _____

Unable to obtain information (reason) _____

Vital Signs: T _____ B/P _____ P _____ R _____ O_2 Sat _____ (on Room Air)

ALLERGY INFORMATION - ENTER INTO COMPUTER

Date	Type of Allergy	Reaction	Nurse Signature	Date	Type of Allergy	Reaction	Nurse Signature
	Latex? ❒ No ❒ Yes						
	Nuts/Legumes? ❒ No ❒ Yes						

Anesthesia reaction in the past? ❒ No ❒ Yes Explain _____

Recent infection? ❒ No ❒ Yes Explain _____

Any current open wounds or skin problems / conditions? ❒ No ❒ Yes Explain: _____

Are you participating in any research studies? ❒ No ❒ Yes If Yes, call x57527.

FOR PATIENTS 65 YEARS OR OLDER: If NO, to either question below, see referral section Infection Control

Pneumococcal Vaccine received within last 5 years? ❒ No ❒ Yes

Flu Vaccine in past 12 months? ❒ No ❒ Yes

SURGICAL PROCEDURES, OPERATIONS, HOSPITALIZATIONS (type, when)

MEDICATIONS BROUGHT TO HOSPITAL: ❒ No ❒ Yes Disposition: ❒ Sent home ❒ Sent to pharmacy

Local pharmacy _____

CURRENT MEDICATIONS including over the counter medications, herbal, botanical, sports, or vitamin supplements

Drug / Dose / Frequency	Reason	Last Dose	Drug / Dose / Frequency	Reason	Last Dose

If medication and allergy information collected in ER, review information and initial here _____

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Have you ever experienced or been told that you have:

Patient / family to complete this page when able, and nurse to validate. If patient / family unable, nurse to complete.

DIABETES, THYROID, OR OTHER ENDOCRINE PROBLEMS?

❒ NO
❒ Hypoglycemia (low blood sugar) ❒ Thyroid problems
❒ Diabetes ❒ Other _____

DIGESTIVE, STOMACH, LIVER, GALLBLADDER PROBLEMS?

❒ NO
❒ Hepatitis ❒ Ulcers ❒ Blood in stool ❒ Reflux
❒ Diarrhea/constipation ❒ Inflammatory bowel disease
❒ Ostomy type _____ ❒ Other _____
Home diet _____
Drinking less fluids in the past few weeks? ❒ No ❒ Yes
Appetite: ❒ Good ❒ Fair ❒ Poor
Eating Pattern: ❒ Self ❒ Needs assistance ❒ Tube feed
Eating Concerns: ❒ Chewing problems ❒ Swallowing problems

HEART, CIRCULATION, BLOOD PRESSURE PROBLEMS?

❒ NO
❒ High/low blood pressure ❒ Angina/chest pain
❒ Clotting/bleeding problems ❒ Heart attack
❒ Heart failure ❒ Other _____

HISTORY OF CANCER?

❒ NO
Type of cancer? _____
When diagnosed?

LUNG OR BREATHING PROBLEMS?

❒ NO
❒ Shortness of breath ❒ Home use of oxygen
❒ Asthma/emphysema/bronchitis ❒ History of sleep apnea
❒ History of TB? When? _____
❒ Have you ever smoked? ❒ No ❒ Yes How many years _____
How many per day (cigarettes, cigars, pipe) _____
❒ Other _____

URINARY, KIDNEY, BLADDER PROBLEMS?

❒ NO
❒ Blood in urine ❒ Unable to hold urine
❒ Difficulty / painful urination ❒ Prostate problems
❒ Dialysis ❒ Ostomy type
❒ History of STDs? ❒ Other _____

PSYCHOSOCIAL

❒ Depression ❒ Anxiety ❒ Other _____
Do you feel that you need any additional help/support during this hospitalization? ❒ No ❒ Yes Explain _____
Consume alcoholic beverages? ❒ No ❒ Yes
If yes, how much? _____
When did you have your last alcoholic drink? _____
Have you ever or do you currently use recreational drugs?
❒ No ❒ Yes Describe _____

VALUE / BELIEF SYSTEM / SPIRITUAL CARE

Do you have a faith preference? ❒ No ❒ Yes _____
Would you like us to contact your minister? ❒ No ❒ Yes
Name: _____ Phone: _____
Would you like a visit from our chaplain? ❒ No ❒ Yes
National/cultural preferences _____

ADVANCE DIRECTIVES

Do you have an Advance Directive?

❒ Yes		❒ No	
Copy required for chart. Copy Given to Staff?		Do you want assistance to formulate?	
❒ Yes	❒ No	❒ Yes	❒ No
Staff: Place copy on	Staff: ❒ Request copy	Staff: Give Advance	Staff: No further action

NERVE / MUSCULAR / SKELETAL PROBLEMS?

❒ NO
❒ Alzheimer's /dementia ❒ Stroke ❒ Seizures
❒ Weakness _____ ❒ Numbness _____
❒ Amputation/prosthesis: explain _____
❒ Other _____

SENSORY PROBLEMS?

❒ NO
❒ Cataracts ❒ Glaucoma ❒ Hearing Aids _____
❒ Glasses/contacts ❒ Difficulty speaking/hearing
❒ Other _____

PAIN

Present now or in the last few weeks? ❒ No ❒ Yes

LOCATION (part of body)	DESCRIPTION (see codes)	INTENSITY (0-10 scale)	ONSET TIME	WHAT RELIEVES? (see codes)	WHAT AGGRAVATES? (see codes)

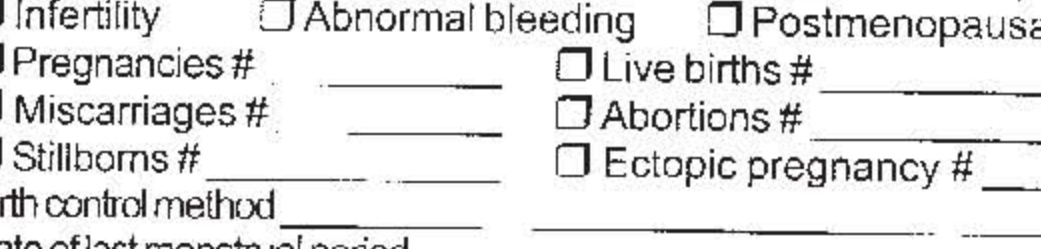
DESCRIPTION CODES:
B=Burning SL=Shock-like D=Dull S=Sharp
Cr=Cramping P=Pressure C=Constant
I=Intermittant Other (describe)

RELIEF/AGGRAVATING FACTOR CODES:
R = Rest A = Activity H = Heat
C = Cold Other(describe)

Pain medication used:

DRUG/DOSE/FREQUENCY	COMMENTS

0 No Pain 2 4 Moderate Pain 6 8 10 Worst Possible Pain



What is your acceptable level of pain? (0-10 scale) _____

FOR WOMEN ONLY: ❒ NOT APPLICABLE

❒ Pelvic pain ❒ Vaginal discharge ❒ Vaginal itching
❒ Infertility ❒ Abnormal bleeding ❒ Postmenopausal
❒ Pregnancies # _____ ❒ Live births # _____
❒ Miscarriages # _____ ❒ Abortions # _____
❒ Stillborns # _____ ❒ Ectopic pregnancy # _____
Birth control method _____
Date of last menstrual period _____
Are you currently breastfeeding? _____
Are you pregnant? _____ (If yes, staff to notify pharmacy)
How many weeks? _____ What is your due date? _____
Last oral intake _____ Are you receiving prenatal care? _____
Pregnancy complications? _____
❒ Other _____

For Pediatric Patients (all patients <19 years)
See Pediatric Data Base Addendum Form #UC4239

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ADMISSION SCREENS: If any block is checked, initiate referral

Case Management (CM)
- ❒ Requires follow-up for advance directive
- ❒ Is patient in any relationship that makes them feel threatened or afraid?
- ❒ Suspect recent abuse, neglect (unexplained injuries, bruises) *Refer to IPP 100.03
- ❒ Emotional support needed
- ❒ **Notified Date/Time** _____ ❒ **No Referral**

Diabetes Care Institute (DCI)
- ❒ New onset diabetes
- ❒ Requires assistive device for Insulin injection
- ❒ Insulin pump patient
- ❒ Diabetes education (>5 years ago)
- ❒ **Notified Date/Time** _____ ❒**No Referral**

Medical Nutrition Therapy (MNT)
- ❒ Unintentional weight loss
  - ❒ Adults: >10 lbs/6 months prior to admission
  - ❒ 4 yrs - 19 yrs: 5% wt loss 2 wks prior to admission
  - ❒ Infant - 48 months: Any wt loss prior to admission
- ❒ Pregnant < **19 Yrs old** with prenatal nutrition knowledge deficit
- ❒ Pregnant with Hyperemesis
- ❒ Special/Restricted diet: Desires education
- ❒ Special religious or cultural diet needs
- ❒ Physician diagnosis of Malnutrition, Failure to Thrive, HIV, Head CA, Neck CA, or Pedi CA
- ❒ Surgical patient with poor oral intake 1 wk prior to admission
- ❒ History of Heart Failure (Pharmacy will also receive referral)
- ❒ Lactating (Non-Women's Center patient) (Pharmacy will also receive referral)
- ❒ Stage I or Stage II pressure ulcer
- ❒ **Notified Date/Time** _____ ❒ **No Referral**

Wound/Ostomy/Continence Nurse (MNT will also receive referral)
- ❒ Stage III or IV pressure ulcer (take photo)
- ❒ Lower extremity wound - vascular, arterial, diabetic (take photo)
- ❒ Open draining wound or fistula (take photo)
- ❒ New ostomy
- ❒ Other skin condition as needed _____
- ❒ **Notified Date/Time** _____ ❒**No Referral**

Infection Control/TB Screen / Vaccines
- ❒ Positive AFB cultures (initiate referral)

If 2 or more items are checked below, initiate referral and assess need for airborne precautions.
- ❒ Night sweats ❒ Unintentional weight loss
- ❒ Current TB ❒ Abnormal chest x-ray
- ❒ Bloody sputum ❒ Recent contact with person with TB

❒**Notified Date/Time** _____ ❒**No Referral**
- ❒ Patients 65 years or older are candidates for Flu Vaccine (October through February). Flu Vaccine Orders (UC2878) to be signed by Physician.
- ❒ Patients 65 years or older are candidates for Pneumococcal Vaccine. Orders (UC2878) to be signed by Physician

Physical Medicine (PM)
New onset of any of the following:
- ❒ Needs moderate assistance with ambulation or transfers
- ❒ Dependent in ADL's
- ❒ Difficulty communicating/swallowing

❒**Notified Date/Time** _____ ❒**No Referral**

Respiratory Services
- ❒ O_2 Sat < 90% on 4L/min via NC
- ❒ O_2 Sat < 90% on room air (only for Pedi < 12 yrs.)
- ❒ Secretions (copious amount)
- ❒ Shortness of breath (severe)
- ❒ Currently smokes or smoked in the last 12 months and requests smoking cessation information

❒**Notified Date/Time** _____ ❒**No Referral**

Spiritual/Emotional Care
- ❒ Requests visit from our chaplain
- ❒ **Notified Date/Time** _____ ❒**No Referral**

Document contact with personal minister:

ORIENTATION TO UNIT ❒ **Patient** ❒ **Family**
- ❒ ID band correct
- ❒ Bed controls and call bell
- ❒ Electrical policy
- ❒ Location of bathroom
- ❒ Bathroom emergency light
- ❒ Unit specific policies
- ❒ Smoking policy
- ❒ Educational channel
- ❒ Hearing impaired devices
- ❒ Monitoring instructions
- ❒ Telephone
- ❒ Visiting policy
- ❒ Clinical Alarms
- ❒ Bathing routines
- ❒ Home equipment at bedside requires staff to complete Patient Owned Equipment Inspection Form (UC4281).

BELONGINGS	None	Bedside	Home	Security
Clothing ❒ Pants/Skirt ____ ❒ Shoes ____ ❒ Shirt ____ ❒ Jacket ____				
Other				
Meds				Notify Pharmacy

VALUABLES	None	Bedside	Home	Security
Money				
Jewelry				
Dentures				
Hearing Aid ❒ L ❒ R ❒ Both				
Glasses				

I fully understand that I am responsible for the items I keep with me and release University Community Hospital from any responsibility for these items.

Signature of Patient (Or family member only if patient unable to sign) Signature of Relative/Friend (Taking items home) Relationship

Staff Signature _____ Date _____ Time _____

LPN/RN Completing Database: _____ Date_____Time_____

This verifies RN has reviewed history, screening data, and physical assessment data, and has identified and prioritized interdisciplinary problems. Consults have been made if applicable.

RN SIGNATURE: _____ Date_____Time_____

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EDUCATIONAL DATA ❒ Patient ❒ Family ❒ Support person

Do you have any questions/educational needs about your health condition or treatment? ❒ No ❒ Yes _____

Do you have any Spiritual or Cultural needs concerning your care that we need to be aware of? ❒ No ❒ Yes _____

Ability to grasp concepts (follows directions, expresses thoughts adequately): ❒ High ❒ Medium ❒ Low

Readiness to learn: ❒ Asks questions ❒ Eager to learn ❒ Extremely anxious ❒ Denies need for education

Knowledge of current health status: ❒ No knowledge ❒ Verbalizes only partial understanding ❒ Verbalizes understanding

Barriers to Learning/Communication: Able to read ❒ No ❒ Yes Highest education level _____

❒ Physical _____ ❒ Cognitive _____ ❒ Emotional _____

❒ ***NO BARRIERS IDENTIFIED***

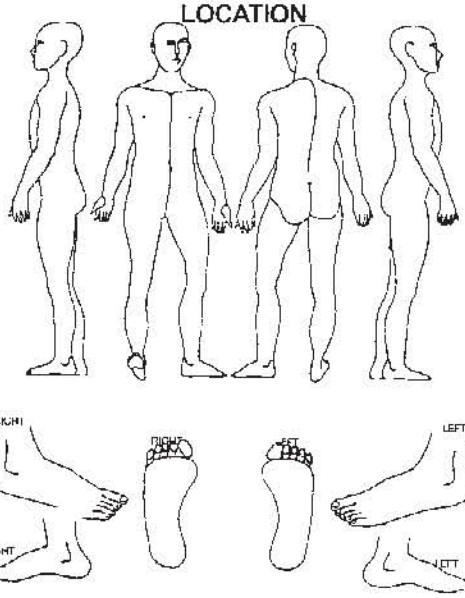
Primary Language _____ ❒ Understands English

Shaded areas on page 4 assessed: ❒ **No Consult** ❒ **CM** ❒ **MNT** ❒ **PM**

Ambulatory Care / RN _____ **Date** _____ **Time** _____

WOUND TYPES:

LOCATION



- **Pressure ulcer**
- **Venous stasis**
- **Arterial**
- **Diabetic**
- **Burn**
- **Trauma**
- **Other**

STAGE (pressure ulcer only)
I. Epidermis is red (erythema and nonblanchable)
II. Epidermis is lost. Looks like blister, skin tear, or abrasion
III. Loss of epidermis and dermis exposing SQ tissue.
IV. Full-thickness loss of skin exposing bone, muscle, tendon.
V. Unable to stage due to necrotic tissue.

TISSUE LEVEL
A. Partial thickness B. Full thickness

WOUND COLOR
1. Pink 2. Red 3. Yellow
4. Black 5. Pale

SURROUNDING SKIN
1. Healthy, intact 2. Erythema
3. Ecchymosis 4. Macerated
5. Indurated 6. Spongy
7. Change in pigment

DRAINAGE
0. None
1. Serous
2. Serosanguinous
3. Sanguinous
4. Opaque

DRAINAGE AMOUNT
0. None
1. Scant moist
2. Small = < 25% of 1 dressing
3. Moderate = approx. 50% of dressing
4. Saturates entire dressing

ODOR
0. None 1. Mild
2. Foul 3. Sweet

EVALUATION
1. Initial 2. Improved
3. Unchanged 4. Deteriorated
5. Debrided

DEFINITION OF TERMS

Partial Thickness - loss of epidermis, usually painful, shallow, pink/red colc
Full Thickness - extends below dermis into subcutaneous layer or deeper

DRAINAGE TYPE
Serous - clear yellow in color
Serosanguious - blood tinged, combination of serous and bloody drainage
Sanguious - bloody
Opaque - not translucent, can be green, yellow, tan in color

SURROUNDING SKIN COLOR
Macerated - softening of tissue by soaking in fluids, white in color
Indurated - Abnormal firmness of tissue with a definite margin
Spongy - soft upon palpation

* Take photos of all pressure ulcers and other significant wounds upon admission or when first identified.

* For skin tears, abrasions, and Stage I and Stage II pressure ulcers, initiate Treatment Protocol.

Use keys above or place ✔ in column if completed

SITE Location	Site No.	Wound Color	Surrounding Skin Color	Drainage Type	Drainage Amount	Odor	Dressing Change	Dressing Dry and Intact	Stage or Tissue Level	SIZE IN Cm* L	W	D	EDEMA Yes / No	Tunneling/ Undermining Yes / No	Evaluation	Photo Taken	Physician Notified	Comments	Signature

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