**For In & Out Surgery Patients, complete shaded areas**

**ADMISSION DATA BASE**

**Page 1**

**PATIENT IDENTIFICATION**

- **Name of Med**: 
- **Dose/Schedule**: 
- **Last Dose**: 

**CURRENT MEDICATIONS**

- **Disposition of Medication**: 
  - **N/A**
  - **Home**
  - **Given to Family**
  - **Bedside**
  - **Valuables Envelope**

**DRUGS - Type (Cocaine, Heroin, etc.)**

**ALCOHOL - Amount**

**SMOKING - How many packs/day?**

**For how many years?**

**Smoking Cessation Information given?**

- **Yes**
- **No**
- **N/A**

**LIFE STYLE**

- **Stress in your life (health, relationships, finances):**
- **Recent changes/losses (job, move, new baby, divorce, death):**
- **What do you do under stress?**
- **Due to the increase in domestic violence, we ask all adult patients. "Are you being hurt, hit or frightened by anyone in your life?"**
  - **Yes**
  - **No**

**COPING / STRESS**

- **Would you like assistance in dealing with this problem?**
  - **Yes**
  - **No**

**Previous Psychiatric Therapy / Counseling / Admissions:**

- **None**

**SPRITUAL - CULTURAL**

- **Do you have any spiritual or cultural practices than may affect your medical care or hospitalization?**
- **Yes**
- **No**

**ADVANCED DIRECTIVES**

- **Do you have Advanced Directives?**
  - **Yes**
  - **No**

- **Copy placed on chart?**
  - **Yes**
  - **No**

- **Date:**

**Do you have a Durable Power of Attorney for Health Care decision making?**

- **Yes**
- **No**

**Written information on advanced directives given to patient?**

- **Yes**
- **No**

**PART OF THE MEDICAL RECORD**
For In & Out Surgery Patients, complete shaded areas

SENSORY / COGNITION

Hearing:
- Impaired
- R
- L
- Aid

Vision:
- Impaired
- R
- L
- R
- L
- Glasses
- Contacts
- Eye Prosthesis

Comment:

Are you having any difficulty reading?
- Yes
- No

Explain:

Sleep / Rest Problems:
- Yes
- No

If "Yes", what do you do at home to sleep?

ACUTE PAIN:
- No Acute pain

Location:
- Intensity (0-10):
- Scale

Comfort Goal:
- Quality (Patient's own words):

Onset:
- Pattern

Aggravating Factors:

Alleviating Factors:

Functional Ability:
- Impact on Quality of Life:

PAIN MANAGEMENT HISTORY:
- Helpful:
- NOT Helpful:

CHRONIC PAIN:
- No Chronic pain

Location:
- Intensity (0-10):
- Scale

Comfort Goal:
- Quality (Patient's own words):

Onset:
- Pattern

Aggravating Factors:

Alleviating Factors:

Functional Ability:
- Impact on Quality of Life:

PAIN MANAGEMENT HISTORY:
- Helpful:
- NOT Helpful:

PAIN SCALES:

WONG-BAKER

0-10 VISUAL:
- (Numerical)

VERBAL:
- No Hurt
- Hurts Little Bit
- Hurts Little More
- Hurts Even More
- Hurts Whole Lot
- Worst Pain

NON-COGNITIVE:
- (FLACC Scale)

SEDATION SCALE:

S:
- NORMAL SLEEP, EASY TO AROUSE, ORIENTED WHEN AWAKENED, APPROPRIATE COGNITIVE BEHAVIOR

FACE:
- WIDE AWAKE - ALERT (OR AT BASELINE), ORIENTED, INITIATES CONVERSATION

ACTIVITY:
- DIFFICULT TO AROUSE, CONFUSED, NOT ORIENTED

CONSOLABILITY:
- UNAROUSABLE

INTERVENTION:

1:
- DISCUSS PAIN MANAGEMENT PLAN WITH PHYSICIAN

2:
- PHARMACOLOGICAL (See MED KARDEX)

3:
- NON-PHARMACOLOGICAL

LMP:
- Pregnancy Hx:
- Gr
- P
- A

Type of Delivery:
- Full-Term
- Pre-term
- Vaginal
- C / S

STD's:

Sexual Function Issues:

Contraception:

FLACC PAIN SCALE: 1. Sum of FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY Scores = FLACC
2. Record FLACC Score using the 0-10 VISUAL (NUMERIC) Scale above

- FACE Score
- LEGS Score
- ACTIVITY Score
- CRY Score
- CONSOLABILITY Score

PART OF THE MEDICAL RECORD
For In & Out Surgery Patients, complete shaded areas

### HISTORY

- **No Impairment**
- **Hypertension**
- **Pacemaker**
- **Angina / Chest Pain**
- **Palpitations / Dysrhythmias**
- **Very Cold / Numb Extremities**
- **DVT / PE**
- **CABG**
- **Other (Specify)**

#### CARDIOVASCULAR
- **Skin Condition**
- **Color:** Normal, Pale, Cyanotic, Other (specify)
- **Radial Pulse:** Regular, Irregular
- **Pedal Pulse:** Present, Absent
- **Edema:** None, R Arm, L Arm, R Leg, L Leg
- **Vascular Access (specify kind & location):**

#### RESPIRATORY
- **CHF**
- **Color:** Normal, Pale, Cyanotic, Other (specify)
- **Apical Pulse:** / min
- **Apical Pulse:**
- **Radial Pulse:**
- **Pedal Pulse:**
- **Foot Pulse:**
- **Edema:** None, R Arm, L Arm, R Leg, L Leg
- **Comments:**

#### RESPIRATORY
- **Orthopnea**
- **Dyspnea**
- **Tachypnea**
- **SOB**
- **Cough**
- **Sputum Production**
- **Specify Color:**
- **Specify Amt:**

#### NUTRITIONAL
- **Unplanned weight loss (10-15 lbs) in the last 6 months:** Yes, No
- **Difficulty chewing or swallowing:** Yes, No
- **If yes, Liquids?** Yes, No
- **Oxygen:** None, Upper, Lower, Partial
- **N/G Tube**
- **Small-bone Feeding Tube**
- **PEG Tube**
- **Gastrostomy Tube**

#### NUTRITIONAL
- **Abdominal Soft**
- **Abdominal Tender**
- **Abdominal Distended**
- **Bowel Sounds:** Present, Absent
- **Foley Catheter**
- **Urostomy**
- **Colostomy / Ileostomy**
- **External Catheter**

#### Bowel:
- **Diarrhea**
- **Constipation**
- **Rectal Bleeding**
- **Incontinence**
- **Last BM**
- **Usual Pattern**

#### Bladder:
- **Urgency**
- **Nocturia**
- **Incontinence**
- **Burning**
- **Retention**
- **Frequency**
- **Anuria**
- **Dialysis**

#### Bowel:
- **No elimination problems noted**

#### EDUCATION
- **Patient's preference for learning information:** TV / Video, Reading, Teaching 1:1, Groups, Tapes
- **Interdisciplinary Patient Educational Assessment Form Initiated:** Yes, No

#### DISCHARGE ASSESSMENT (ANTICIPATED ASSISTANCE NEEDED)
- **Place of Residence:** Home, Nursing Home, Res. Facility, Senior Housing, Shelter, Homeless
- **Source of Medical Care:** None, Private MD, Clinic, Other
- **Health Services at Home:** None, Nurse, Homemaker, Social Worker, PT, OT, Speech, Hospice, Other
- **Do you feel you will need additional help with care at home?** No, Yes (describe)

#### REASONS FOR REFERRALS
- **Case Management Dept**
- **Food & Nutrition Services**
- **Rehabilitative Services**
- **Wound, Ostomy & Continence Nurse (ET)**

**PART OF THE MEDICAL RECORD**

8850016 Rev. 03/05
**ADMISSION DATA BASE**

For In & Out Surgery Patients, complete shaded areas

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
<th>FALL RISK ASSESSMENT CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAIT: Normal: Abnormal:</td>
<td>INSTRUCTIONS: For any &quot;YES&quot; response, initiate the Fall Risk Assessment Protocol and include safety problem on Patient Care Portfolio.</td>
</tr>
</tbody>
</table>

- **No musculoskeletal problems**
- **Limited ROM:** Rt. Arm Lt. Arm Rt. Leg Lt. Leg
- **Amputation:** Rt. Arm Lt. Arm Rt. Leg Lt. Leg
- **DEVICES:** Cane Quad Cane Crutches Walker
- **INSTRUCTIONS:**
  - A. History of falls, use of restraints: Yes No
  - B. Ambulation / gait problems, use of adaptive devices (i.e., canes, walkers, prosthesis): Yes No
  - C. Weakness / paresis: Yes No
  - D. Confusion, disorientation, impulsiveness, agitation, combativeness, seizures: Yes No
  - E. Incontinence / urgency, diarrhea, frequent toileting: Yes No
  - F. Post-op within 48 hours, sedatives, narcotic analgesics: Yes No

<table>
<thead>
<tr>
<th>PRE ADMISSION:</th>
<th>REHAB TRIGGERS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMBULATION: Self Assist Complete</td>
<td>A &quot;YES&quot; answer to above items triggers request to physician for consult for appropriate rehab discipline</td>
</tr>
<tr>
<td>DRESSING: Self Assist Complete</td>
<td>PT - Recent and significant decline in functional mobility (ambulation, transfers, bed mobility): Yes No</td>
</tr>
<tr>
<td>MEAL PREPARATION: Self Assist Complete</td>
<td>OT - Recent and significant change in ADL’s: Yes No</td>
</tr>
<tr>
<td>FEEDING: Self Assist Complete</td>
<td>Speech - Consistently coughs when eating and/or drinking: Yes No</td>
</tr>
<tr>
<td>BATHING: Self Assist Complete</td>
<td></td>
</tr>
<tr>
<td>TOILETING: Self Assist Complete</td>
<td></td>
</tr>
</tbody>
</table>

| PHYSICAL MARKINGS: Any Pressure Ulcer should be staged, measured & described in Admitting Nurse’s Notes. |
|-------------------|-------------------------------------------------------------|
| ABRASIONS | PRESSURE ULCERS * |
| SCARS | HEALED PRESSURE ULCER * - or - FLAP * |
| CONTUSIONS | OTHER |
| RASH | |

- **OBtain Dietary Consult + Stamp ORDER SHEET w/ Serum Albumin Request**

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**BRADEN SCORE FOR PREDICTING PRESSURE ULCER RISK**

**INSTRUCTIONS:** Circle the number in each column that best describes the criteria.

<table>
<thead>
<tr>
<th>SENSORY PERCEPTION</th>
<th>MOISTURE</th>
<th>ACTIVITY</th>
<th>MOBILITY</th>
<th>NUTRITION</th>
<th>FRICTION &amp; SHEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 COMPLETELY LIMITED</td>
<td>1 CONSTANTLY MOIST</td>
<td>1 BEDREST</td>
<td>1 COMPLETELY IMMOBILE</td>
<td>1 VERY POOR</td>
<td>1 PROBLEM</td>
</tr>
<tr>
<td>2 VERY LIMITED</td>
<td>2 VERY MOIST</td>
<td>2 CHAIRFAST</td>
<td>2 PROBABLY INADEQUATE</td>
<td>2 POTENTIAL PROBLEM</td>
<td></td>
</tr>
<tr>
<td>3 SLIGHTLY LIMITED</td>
<td>3 OCCASIONALLY MOIST</td>
<td>3 WALKS OCCASIONALLY</td>
<td>3 SLIGHTLY LIMITED</td>
<td>3 NO APPARENT PROBLEM</td>
<td></td>
</tr>
<tr>
<td>4 NO IMPAIRMENT</td>
<td>4 RARELY MOIST</td>
<td>4 WALKS</td>
<td>4 NO LIMITATIONS</td>
<td>4 EXCELLENT</td>
<td></td>
</tr>
</tbody>
</table>

A total score of < 17 = high risk pressure ulcer patient. Implement Pressure Ulcer Prevention Protocol.

**TOTAL SCORE:**

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**ADMISSION DATA BASE**

**NURSING NOTES**

**PRINT NAME / TITLE**

**SIGN NAME**

**DATE**

**Military Time**

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**PART OF THE MEDICAL RECORD**