**SECTION 1: GENERAL ADMISSION/HEALTH HISTORY (Patient, PCT, RN)** *Patient/Family may answer

*Date: _____ Time: _____ Admitted From: _____

Historian: ☐ Patient ☐ Other _____ VIA: ☐ Stretcher ☐ WC ☐ Ambulatory

Patient Identification Band in place: ☐ yes

*Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Religion _____

Reason for admission:

Emergency Contact: Name: Relationship: Phone: (H) (W) (C)

| Age | Sex ☐M ☐F | Race | Height ☐ Actual | Weight ☐ Actual |
|---|---|---|---|---|
| | | | | |

*MAJOR ILLNESS/INJURIES/PREVIOUS SURGERIES/ENDOSCOPIC PROCEDURES ENTER YEAR OR AGE ☐ NONE

| *ALLERGIES: Type and Reaction | Medication: ☐ yes ☐ no ☐ unknown | Food: ☐ yes ☐ no ☐ unknown | Environment: ☐ yes ☐ no ☐ unknown |
|---|---|---|---|
| | | | |
| | ☐ Latex ☐ Latex screening tool completed ☐ Yes ☐ No ☐ Unknown | | |

Immunization:

Pneumovac: ☐ Y ☐ N Date: _____ Flu: ☐ Y ☐ N Date: _____ Tetanus: ☐ Y ☐ N Date: _____

*CURRENT MED/DOSE/SCHEDULE/LAST DOSE ☐ NO MEDICATIONS TAKEN REGULARLY ☐ Ø HOLD MEDS DOS

☐ HOMEOPATHICS[11]:

☐ HERBALS[11]:

☐ Rest/Sleep: Hours _____ ☐ Naps

☐ Difficulty falling asleep

☐ Difficulty staying asleep

*Nutrition Status

☐ Loss of Appetite/Poor Intake > 5 Days[2]

☐ Unintentional Weight Loss > 5 lbs/mo[2]

☐ Tube Feeding/TPN[2] Type: _____

☐ Coffee/Tea/Cola # of Cups/Day: _____

Alcohol Amount: _____ Last Drink: _____

☐ Diet/Nutrition Counseling Requested[2]

☐ Information Unavailable ☐ Denies All Above

PSYCHOSOCIAL ASSESSMENT

Source of Support: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Other

**☐ Work ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed

☐ Occupation _____

**☐ No means of support ☐ Other _____

☐ Patient is caregiver for someone else

☐ Alcohol Quantity _____ drinks/day/week

☐ Recreational Drugs type _____ frequency _____ ☐ Last dose

**☐ Denies Substance Abuse

*FUNCTIONAL ASSESSMENT/DISCHARGE CONSIDERATIONS

*Home Environment:

☐ Nursing/Group[1] ☐ House ☐ Apartment

☐ Stairs ☐ Elevator ☐ Homeless[1]

*Lives With:(if not in nursing/group home)

☐ Alone[1] ☐ Spouse ☐ Children

☐ Will Have Help Following Hospitalization

☐ Other _____

*Level of Care: ☐ Independent

(ADL's) ☐ Needs Assistance[1] Caregiver _____

☐ Needs Assistance (No Help Available)[1] Type _____

*Mobility: ☐ Bed Bound ☐ Ambulatory ☐ Needs Assistant ☐ WC ☐ Walker/Cane ☐ Prosthesis

Expected Change In: ☐ ADL's[1,4] ☐ Mobility[1,4] ☐ NA

Transportation After Hospitalization: ☐ Family/SO car ☐ Taxi/Bus ☐ Ambulance/Special Van[1] ☐ Not known at this time

☐ Blind: ☐ R ☐ L Visual Loss: ☐ R ☐ L Hearing Loss: ☐ R ☐ L

Speech Deficit: ☐ Aphasic ☐ Slurred ☐ Nonverbal

Language: ☐ English ☐ Spanish[15] ☐ Other:[15] _____

Interpreter Needed? ☐ Yes[15] Name: _____

Phone (H) _____ (W) _____

**(Note)**: If interpreter not provided by family, refer to Patient Care Policy

Patient Identification

Hospital

**DEPARTMENTS OF NURSING**

**Patient History**

8010-167 (03/05)

**CULTURAL/SPIRITUAL FACTORS** ☐ None

☐ Cultural preferences _____ ☐ Spiritual preferences _____

☐ Religious preferences _____ ☐ Other _____

☐ Ethnic food preferences _____

## SECTION 2: PHYSICAL FUNCTIONING (RN)

Gait: ☐ Steady ☐ Unsteady[4] ☐ Unable to Assess ☐ History of Falls

☐ Fracture[4] Site: _____

☐ Neurovascular Assessment Initiated ☐ Other: _____

☐ Confused/Disoriented ☐ No Problems Noted

## SECTION 3: INTIMATE PARTNER DOMESTIC VIOLENCE

*Are you in a relationship with a person who threatens you in any way, physically hurts you or forces you to do things that make you feel uncomfortable? ☐ Yes[1,14] ☐ No

## SECTION 4: PAIN

☐ History of Significant Pain *Method used to relieve pain:* _____

☐ Denies all of above

## SECTION 5: PEDIATRIC (Parent/Guardian, RN) To Be Completed For Any Patient Under 18 Years ☐ NA

***Pre-Natal History**

Length of pregnancy: _____

Complications: ☐ Yes ☐ No Type: _____

Neonatal problems ☐ Yes ☐ No Type: _____

Maternal problems ☐ Yes ☐ No

***Development History**

Patient is developing normally physically and psychologically

☐ Yes ☐ No If no, describe: _____

List activities, i.e., walking, toilet trained, tie shoes, feeds self, coloring,

Has friends/activities outside of family: _____

***Immunization History**

Are immunizations up-to-date? ☐ Yes ☐ No/Unsure If no/unsure, instruct parent/guardian to contact their physician.

Has child recently been exposed to any infectious diseases? ☐ Yes ☐ No If yes, describe: _____

When: _____

## *VALUABLES: ☐ Personal Property List Attached

| | Sent Home | Room Safe | None | | Sent Home | Room Safe | None |
|---|---|---|---|---|---|---|---|
| Clothes | ☐ | ☐ | ☐ | Prosthesis | ☐ | ☐ | ☐ |
| Hearing Aid | ☐ | ☐ | ☐ | Jewelry | ☐ | ☐ | ☐ |
| Walker,Cane,WC | ☐ | ☐ | ☐ | Watch | ☐ | ☐ | ☐ |
| Wallet | ☐ | ☐ | ☐ | Rings | ☐ | ☐ | ☐ |
| Money | ☐ | ☐ | ☐ | Credit Cards | ☐ | ☐ | ☐ |
| Medication | ☐ | ☐ | ☐ | | | | |

Dentures: ☐ Upper ☐ Lower ☐ Partial ☐ Full

☐ Glasses ☐ Contacts

Other: _____

## SECTION 6: GENERAL APPEARANCE (RN)

**General Appearance**

☐ Groomed ☐ Unkept

☐ Unexplained Bruises/Trauma[1,14]

**INTEGUMENTARY**

☐ Previous Pressure Ulcer/Wound ☐ Rashed/Inflamm

☐ Location ☐ Resolved ☐ Unresolved

☐ Denies all of the above

## SECTION 7: RELEVANT HISTORY (Patient, PCT, RN)

### *RESPIRATORY

- ☐ SOB (Short of Breath)
- ☐ Asthma[3]
- ☐ COPD[3]
- ☐ Pneumonia[3]
- ☐ Chest X-ray Date:_____
- ☐ Other Respiratory Disease
- ☐ Resp failure[3]
- ☐ TB[3]
- ☐ Sleep Apnea[3]
- ☐ Chronic, Frequent Cough
- ☐ Frequent Colds/Sore Throat
- ☐ Hemoptysis

Oxygen Used: ☐ Yes[1,3] ☐ No Amount: _____

# of Pillows Used at Sleep: _____

Smoker: ☐ Yes[3] ☐ No ☐ Former smoker < 1 year[3]

Packs Per Day:_____X_____yrs Years quit: _____

☐ Information Unavailable ☐ Denies All Above

### *GASTROINTESTINAL

☐ Usual Diet: _____ ☐ Vegetarian ☐ Meat

☐ Diet Restrictions: _____

☐ Trouble Swallowing ☐ Heartburn

☐ Liver Disease ☐ Hepatitis ☐ Hemorrhoids

☐ Hiatal Hernia ☐ Stomach Ulcers

Bowel Habits - Frequency: _____ ☐ Color _____

Date of Last BM: _____

☐ Constipation ☐ Diarrhea

☐ Information Unavailable ☐ Denies All Above

### REPRODUCTIVE: ☐ Male ☐ NA

- ☐ Hernia
- ☐ Penile Discharge
- ☐ Testicular ☐ pain ☐ mass
- ☐ Hx of STD
- ☐ Denies all of the above

### MUSCULOSKELETAL

- ☐ Muscle/Joint Pain
- ☐ Arthritis
- ☐ Backache
- ☐ Stiffness
- ☐ Gout
- ☐ Denies all of the above

### HEMATOLOGIC

☐ Anemia ☐ Blood Disease ☐ Immunocompromised[2] ☐ HIV

☐ Bleeding Tendency: Cause: _____

☐ Blood Transfusion Date: _____ Reaction: ☐ Yes ☐ No

Type of Reaction: _____

☐ Cancer

☐ Recent Chemotherapy/Radiation ☐ Denies All Above

### ENDOCRINE

☐ Diabetic:

☐ Recent Onset[2,7] (<12 months) ☐ Uncontrolled[2,7]

☐ PO Med ☐ Diet Control ☐ Insulin

☐ Gestational Diabetes[2] Onset Date: _____

Previous Diabetic Education: ☐ Yes ☐ No Date: _____

☐ Thyroid Disorder

☐ Heat or Cold Intolerance

☐ Excessive Sweating

## SECTION 8: NURSING PROCESS (RN)

☐ Patient Problem Statement Identified:: _____

☐ Clinical Pathway(s): _____

### *CARDIOVASCULAR

- ☐ Hypertension
- ☐ Hypotension
- ☐ Dizziness
- ☐ Ankles/Feet Swelling
- ☐ Congestive Heart Failure[6]
- ☐ Irregular Heart Beat
- ☐ Angina/Chest Pain
- ☐ Heart Attack Date: _____
- ☐ EKG Date: _____
- ☐ Pacemaker Date: _____
- ☐ Internal Defibrillator Date: _____
- ☐ Open Heart Surgery Type: _____ Date: _____
- ☐ Cardiac Catheterization Date: _____
- ☐ Other Heart Disease: _____
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Cardiovascular Disease
- ☐ Peripheral Vascular Disease
- ☐ Aspirin Therapy
- ☐ Rheumatic Fever
- ☐ Varicose Veins
- ☐ Family Hx of: _____

☐ Information Unavailable ☐ Denies All Above

### *GENITAL/URINARY

- ☐ Renal Stones
- ☐ Renal Disease ☐ Dialysis
- Urinates with Difficulty: ☐ Yes ☐ No
- Frequent Urinary Tract Infection: ☐ Yes ☐ No
- Prostate Problems: ☐ Yes ☐ No Describe _____
- ☐ Penile Implant

☐ Information Unavailable ☐ Denies All Above

### REPRODUCTIVE FEMALE ☐ NA

☐ Age at Menarche ☐ LMP_____

☐ Hx of STD

### PREGNANCY ☐ N/A ☐ Yes ☐ No

Gravida: _____ Para: _____

☐ Hypertension ☐ Poor Fetal Outcome

☐ Other: _____

☐ Hyperemesis[2]

☐ Information Unavailable ☐ Denies All Above

### *NEUROLOGICAL:

- ☐ Seizures
- ☐ Brain Attack (Stroke)[4,9]
- ☐ Fainting Spells
- ☐ Falls
- ☐ Weakness ☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg
- ☐ Paralysis ☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg
- ☐ TIA
- ☐ Migraine Headaches
- ☐ Anxiety[1]
- ☐ Depression[1]
- ☐ Mental Illness[1]
- ☐ Contractures ☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg

☐ Information Unavailable ☐ Denies All Above

## SECTION 9: REFERRALS (RN)

**Obtain Physician's Order for Consultation

| | | Order # | Init |
|---|---|---|---|
| ☐ | No Referrals Noted | | |
| ☐ 1. | Case Management/Psych | | |
| ☐ 2. | Nutritional Services | | |
| ☐ 3. | Respiratory | | |
| ☐ 4. ** | Rehab Medicine / OT | | |
| ☐ 5. ** | ET/Wound Management | | |
| ☐ 6. | Pain Management | | |
| ☐ 7. | Diabetes | | |
| ☐ 8. | Cardiology | | |
| ☐ 9.** | Speech Therapy | | |
| ☐ 10. | Lactation Consultant | | |
| ☐ 11. | Clinical Pharm. | | |
| ☐ 12. | IV Therapy | | |
| ☐ 13. | Patient Relations | | |
| ☐ 14. | Pastoral Care | | |
| ☐ 15. | Cultural Liaison | | |

**RN SIGNATURE:** **DATE:** **TIME:**

| VITAL PARAMETERS | 7 - 2 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| TIME | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| TEMP | | | | | | | | |
| PULSE | | | | | | | | |
| Resp. | | | | | | | | |
| BP (cuff) | | | | | | | | |
| BP (A-line) | | | | | | | | |
| Mean A-BP | | | | | | | | |
| $O_2$ Sat | | | | | | | | |
| 15 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| 30 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| 45 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| CVP | | | | | | | | |
| P.A. S/D | | | | | | | | |
| PAMP | | | | | | | | |
| PAWP | | | | | | | | |
| C.O./C.I. | | | | | | | | |
| SVR | | | | | | | | |
| Sedation Level | | | | | | | | |
| Pain Level | | | | | | | | |
| HoB Elevation | | | | | | | | |
| 23-06 Total | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |
| 12 | | | | | | | | |
| 13 | | | | | | | | |
| | | | | | | | | |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| | | | | | | | | |

| VITAL PARAMETERS | 8 - 10 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| TIME | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| TEMP | | | | | | | | |
| PULSE | | | | | | | | |
| Resp. | | | | | | | | |
| BP (cuff) | | | | | | | | |
| BP (A-line) | | | | | | | | |
| Mean A-BP | | | | | | | | |
| $O_2$ Sat | | | | | | | | |
| 15 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| 30 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| 45 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| CVP | | | | | | | | |
| P.A. S/D | | | | | | | | |
| PAMP | | | | | | | | |
| PAWP | | | | | | | | |
| C.O./C.I. | | | | | | | | |
| SVR | | | | | | | | |
| Sedation Level | | | | | | | | |
| Pain Level | | | | | | | | |
| HoB Elevation | | | | | | | | |
| 07-14 Total | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |
| 12 | | | | | | | | |
| 13 | | | | | | | | |
| | | | | | | | | |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| | | | | | | | | |

Date:

RN Initials/Signature:

| | | |
|---|---|---|
| 11-7 | | |
| 7-3 | | |
| 3-7 | | |
| 7-11 | | |
| 3-11 | | |

PREVIOUS 24 HR I & O

| INTAKE | OUTPUT |
|---|---|
| | |

| DAILY WEIGHT | lbs. |
|---|---|
| | kg. |

**Pain Scale: PT"s Perception**

0 = No pain
1-3 = SI discomfort moves without help
4-5 = Medium discomfort
Hesitant movement
7-9 = Severe pain strained expression
will not move
10 = Very severe pain
Writing or sweating
↑ HR ↑ BP

| 15-22 Total | 24hr. Total |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |
| 11 | |
| 12 | |
| 13 | |
| | |
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| | |

| Date: | Day: |
|---|---|
| **LAB TEST RESULTS** | |
| Time | |
| Na | |
| K | |
| CL | |
| CO2 | |
| BUN | |
| Creat. | |
| Glucose | |
| Calcium | |
| Magnesium | |
| Phosphorus | |
| WBC | |
| Hb | |
| Hct | |
| PTT | |
| PT | |
| INR | |
| Platelets | |
| CPK Total | |
| MB | |
| Troponin Level | |
| Myoglobin Level | |
| LDH Total | |
| Albumin (total) | |
| Drug Level | |
| Peak | |
| Trough | |
| | |
| | |
| | |
| | |
| | |
| | |

| Routine Cares | 7-3 | 3-11 | 11-7 |
|---|---|---|---|
| Shampoo/Shave AM/PM Care | | | |
| Teds/Compression Hose | | | |
| Oral Hygiene | | | |
| Peri-Care | | | |
| Therapeutic Bed | | | |
| Universal Precautions | | | |
| Range of Motion PRN | | | |
| Eye Care | | | |
| Trach. Care | | | |
| Fall Precautions | | | |
| | | | |
| **IN PLACE** | **7-3** | **3-11** | **11-7** |
| Central Line* | | | |
| Endotracheal tube* | | | |
| Feeding tube* | | | |
| Epidural | | | |
| Incision: | | | |
| Drains 1. | | | |
| 2. | | | |
| 3. | | | |
| Arterial Line: | | | |

✓ = Present

| VITAL PARAMETERS | 23 | 24 | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|---|---|
| TIME | | | | | | | | |
| TEMP | | | | | | | | |
| PULSE | | | | | | | | |
| Resp. | | | | | | | | |
| BP (cuff) | | | | | | | | |
| BP (A-line) | | | | | | | | |
| Mean A-BP | | | | | | | | |
| $O_2$ Sat | | | | | | | | |
| 15 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| 30 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| 45 Minutes BP | | | | | | | | |
| Pulse | | | | | | | | |
| CVP | | | | | | | | |
| P.A. S/D | | | | | | | | |
| PAMP | | | | | | | | |
| PAWP | | | | | | | | |
| C.O./C.I. | | | | | | | | |
| SVR | | | | | | | | |
| Sedation Level | | | | | | | | |
| Pain Level | | | | | | | | |
| HoB Elevation | | | | | | | | |

| | | 23 | 24 | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|---|---|---|
| INTAKE | 1 | | | | | | | | |
| | 2 | | | | | | | | |
| | 3 | | | | | | | | |
| | 4 | | | | | | | | |
| | 5 | | | | | | | | |
| | 6 | | | | | | | | |
| | 7 | | | | | | | | |
| | 8 | | | | | | | | |
| | 9 | | | | | | | | |
| | 10 **DIET INTAKE** | | | | | | | | |
| | 11 **SUPPLEMENT INTAKE** | | | | | | | | |
| | 12 Tube Feeding | | | | | | | | |
| | 13 Diet: | | | | | | | | |
| | 14 Cumulative Total | | | | | | | | |
| OUTPUT | 1 Urine Output | | | | | | | | |
| | 2 NG Tube | | | | | | | | |
| | 3 Chest Tube | | | | | | | | |
| | 4 Emesis | | | | | | | | |
| | 5 Stool (Liquid) | | | | | | | | |
| | 6 Estimated Blood Loss | | | | | | | | |
| | 7 | | | | | | | | |
| | 8 | | | | | | | | |
| | 9 | | | | | | | | |
| | Cumulative Total | | | | | | | | |

**Table 2 Sedation Scale**

1: Undersedated/agitated: combative, agitated, easily aroused, ventilator dyssynchrony
2: Lightly sedated: cooperative, responds to commands
3: Moderately sedated: only responds to stimuli other than voice.
4: Excessive/oversedation: no response

**CODES**

IV's
NB - New Bag/bottle
DC - Discontinued
TC - Tubing Change

Temp
O - Oral
R - Rectal
T - Tympanic
C - Core

Diet
W - > 75%
F - > 50%
P - > 30%
B - Breakfast
L - Lunch
S - Supper