Memorial Hospital

DATE

IMPRINT WITH PATIENT CHARGE PLATE

PATIENT ADMISSION DATA BASE

Date | Time | Mode: ☐ Ambulatory ☐ Stretcher ☐ Wheelchair | Via: ☐ Admitting ☐ ED | Information Obtained From: ☐ Patient ☐ Family

Religious Preference: **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Lives With: ☐ Spouse ☐ Family ☐ Alone ☐ Other **In:** ☐ House ☐ Apartment ☐ Extended Care ☐ Homeless ☐ Other

Emergency Contact / Relation: **Phone Number:** ☐ **Bracelet Intact**

NURSE'S INITIALS

FUNCTIONAL ASSESSMENT *(May be completed by an RN or LPN)* HEALTH PERCEPTION / HEALTH MANAGEMENT

Reason for Admission:

Patient History (major illnesses / injuries / problems): ☐ Diabetes ☐ Lung Disease ☐ TB ☐ + PPD

☐ Glaucoma ☐ Hypertension ☐ Renal Disease ☐ Coronary Disease

☐ Vascular Disease ☐ Epilepsy ☐ Other:

Surgical History: Operations and dates done:

Operative Site: ☐ N / A ☐ Intact ☐ Other:

Anesthesia Reaction: ☐ N / A Neck Problems: ☐ N / A Jaw Problems: ☐ N / A

Reproductive Health: Last Menstrual Period: Last Self Breast Exam: Last Pap Smear:

Mammogram (> 35 yr): Pap Smear Offered: ☐ Yes ☐ Refused

Self Testicular Exam: Prostate Screen (> 40 yr):

Any sexual concerns?

Smoking History: What: How Much: How Long: Last Use:

Would you like information about how to quit smoking? ☐ Yes ☐ No Info Given: ☐ Yes ☐ No

Alcohol History: What: How Much: How Long: Last Drink:

Street Drugs: What: How Much: How Long: Last Use:

Are you taking any over the counter medications? (Include herbals, vitamins & laxatives)

What medicine do you use for pain and is it effective? ☐ Yes ☐ No Please list last dose below.

NURSE'S INITIALS

MEDICATIONS

Medication / Strength	Freq.	Last Dose

ALLERGIES (Meds, Food, Other)

List Allergies / Type of Reaction

VITAL SIGNS / WEIGHT

BP: L:

BP: R:

P:

R:

T:

HEIGHT:

WEIGHT:

☐ ACTUAL ☐ STATED

Disposition of Medication: ☐ Did Not Bring ☐ Sent Home ☐ Other

NURSE'S INITIALS

DISCHARGE PLANNING *If patient answers "yes" to any question, refer to Case Management, ext 2240.*

	YES	NO	SPECIFY
A. Will living arrangements be a problem after discharge?			
B. Do you have anyone at home who is dependent on you?			
C. Do you currently have home health care?			
Do you have a preference for a home health care provider? Name:			
D. Do you currently have or have ever had medical equipment at home? Type:			
Do you have a preference for a medical equipment provider? Name:			
E. Will you need help from any community agencies for counseling, family planning, Meals on Wheels, etc.?			
F. Do you need information on entitlement (Medicare, Medicaid, Social Security, Disability, etc.)?			
G. Will you need information on Physical therapy, Rehabilitation, Nursing homes or Assisted living?			

NURSE'S INITIALS

FUNCTIONAL ASSESSMENT

COGNITION - PERCEPTION *If in need of an Interpreter - call Volunteer Services - 2507.*
Hearing impaired or Deaf - call Case Management - 2240

Able to Read English: ❑ Yes ❑ No Primary Language if Not English _____
Name and Number of Interpreter _____

Memory Problem (short or long term, transient): ❑ Yes ❑ No
If Yes, Describe: _____

Vision Impairment: ❑ Right ❑ Left ❑ Both

Hearing Impairment: ❑ Right ❑ Left ❑ Both **Hearing Aid:** ❑ Yes ❑ No **With Patient:** ❑ Yes ❑ No

Alteration in Sensory Perception: ❑ Yes Describe: _____

Speech Impairment: ❑ Yes ❑ No *If yes, contact MD for a referral.*

SLEEP / REST / ACTIVITY

Sleep / Rest Pattern (times of day, amount, difficulties, routines, aids, etc.): _____

Usual Activities / Exercise Pattern (exercise routine {kind, frequency, leisure activities, occupation}):

Activities with Which You Usually Need Help: ❑ None
❑ Eating ❑ Dressing ❑ Bathing ❑ Toileting ❑ Grooming ❑ Housework ❑ Moving in Bed
❑ Cooking ❑ Walking ❑ Climbing Stairs ❑ Other: _____

Assistive Devices: ❑ Wheelchair ❑ Cane ❑ Walker ❑ Crutches

Gait: ❑ Not Ambulatory ❑ Bedridden ❑ Steady ❑ Unsteady

Does patient's current functional status differ significantly since onset of current health problem? ❑ Yes ❑ No
If yes, request PT and/or OT referral from MD.

NURSE'S INITIALS

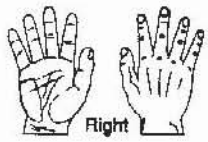
INITIAL PAIN ASSESSMENT

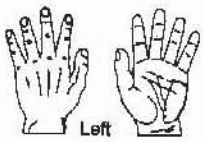
This assessment can be **completed by the patient or Nurse.** ***(The assessment must be reviewed by a RN)***

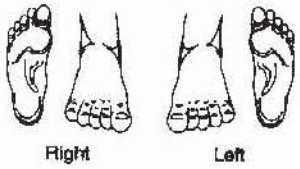
RN Reviewed _____ Person Completing Form _____

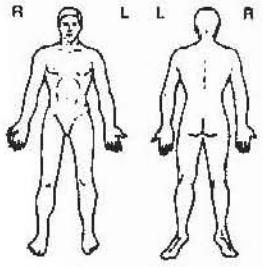
1. Do you have pain today or have you had pain in the last several months? ❑ No ❑ Yes
(If the patient answers yes, please proceed with the assessment)

2. LOCATION: Mark the location(s) with an X where you hurt the most.



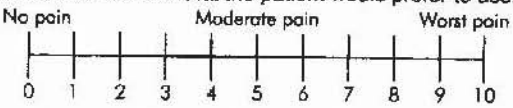




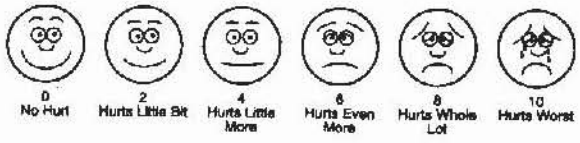


3. Please **select a pain scale** from the 3 choices shown below that the patient would prefer to use. If pain exists today, rate the pain on the scale selected.

❑ **0 - 10 SCALE:**



❑ **FACES:**



❑ **WORD DESCRIPTOR: (WD)**

From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

4. What number would you circle as a **comfort goal**? *(This is not the most pain tolerable, but a number where you could move around, walk, cough and deep breathe and recover quicker.)*
0 1 2 3 4 5 6 7 8 9 10

5. QUALITY: ❑ Aching ❑ Burning ❑ Throbbing ❑ Cramping ❑ Numbness ❑ Prickling ❑ Sharp
❑ Shooting ❑ Soreness ❑ Other _____

6. What time of day is your pain the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Bedtime ❑ Constant ❑ N/A

7. What causes / aggravates the pain? *Check all that apply.*
❑ Sitting ❑ Bending ❑ Walking ❑ Standing ❑ Flexing / Extending ❑ Other _____ ❑ N/A

8. What makes the pain better? *Check all that apply.*
❑ Medication ❑ Rest ❑ Elevation ❑ Activity ❑ Ice / Heat ❑ Other _____ ❑ N/A

9. Does pain interfere with any of the following? *Check all that apply.*
❑ Appetite / Weight ❑ Physical Activity ❑ Sleep ❑ Mood / Emotions ❑ N/A
❑ Ability to Concentrate ❑ Relationships with Others ❑ Other _____

NURSE'S INITIALS

ELIMINATION

Urinary Elimination / Alterations: ☐ None ☐ Frequency ☐ Urgency ☐ Pain / Burning
☐ Other _____ Time Last Voided _____

Bowel Elimination Alterations: ☐ None
☐ Constipation ☐ Diarrhea ☐ Bleeding ☐ Hemorrhoids ☐ Laxative / Enema Use ☐ Other: _____

Usual Bowel Pattern _____ Last BM _____

NURSE'S INITIALS

EMOTIONAL WELL-BEING *The phone extension for the Chaplain is 2708.*

How are you feeling? Sad / Depressed: ☐ Yes ☐ No Anxious: ☐ Yes ☐ No
☐ Other: _____

What are your usual methods of dealing with problems / stress? _____

Have you ever sought professional help for your problems? ☐ Yes ☐ No Specify: _____

Do you have any concerns about your ability to maintain your religious / spiritual / cultural practices / beliefs during your hospitalization?

NURSE'S INITIALS

NUTRITIONAL - METABOLIC

Dentures: ☐ Upper ☐ Lower ☐ None ☐ Partial Diet before Admission: _____

Nutrition Screening (give each factor that applies a score of "1")

Risk Factor	Score	Risk Factor	Score
A. Weight		D. TPN	
• Unscheduled weight loss of 10 lb or more within 3 months		E. Tube reading	
• Grossly underweight / overweight		F. Chewing problems	
B. Patient requests diet education		G. Swallowing problems	
C. Pressure ulcer present or at risk to develop			

Patients with a score of one or more requires a nutrition assessment by a Dietician.
Notify the Nutritionist - Ext 2354
Call Doctor for SLP - Chewing or Swallowing Difficulty

NURSE'S INITIALS

FALL RISK ASSESSMENT

EACH OF THE FOLLOWING EQUALS 1 POINT	SCORE	EACH OF THE FOLLOWING EQUALS 3 POINTS	SCORE
Age 70 or greater		Chronic / episodic confusion	
Urinary / bowel - urgency / incontinence		Unsteady gait	
Chronic debilating disease		History of prior falls	
Use of drugs affecting blood pressure /			
Mental status, urination / defecation		**TOTAL POINTS**	
Sensory deficit		Low risk protocol (0-2 points)	
Postural hypotension		High risk fall prevention protocol	
Depression / hopelessness		Initiated (3 points or greater)	
Neurological dysfunction /		High risk protocol **NOT** initiated	
Mobility deficit		**Due to condition:**	

NURSE'S INITIALS

BELONGINGS / ADVANCE DIRECTIVES

Check appropriate box:			SENT HOME	SECURITY	PT KEPT
☐ Glasses	☐ Contact Lenses				
Dentures:	☐ Upper	☐ Lower ☐ Bridge / Partial			
Caps:	☐ Upper	☐ Lower ☐ Front			

ADVANCE DIRECTIVES / LIVING WILL (AD / LW)

Informed / Bill of Rights:	☐ Yes ☐ No	If you do **NOT** have your AD with you, would you like the doctor to	
Face Sheet Completed for AD / LW	☐ Yes ☐ No	document your directives in your medical record?	☐ Yes ☐ No
Information Given AD / LW	☐ Yes ☐ No	If yes, *NOTIFY PHYSICIAN*	
Does Pt have AD / LW	☐ Yes ☐ No	Copy AD / LW Obt from old chart, signed by Pt	☐ Yes ☐ No
If yes, do you have a copy with you?	☐ Yes ☐ No	Desires more info. AD / LW	☐ Yes ☐ No
If no, can someone bring in a copy?	☐ Yes ☐ No	Does Pt have a durable power of attorney for healthcare	☐ Yes ☐ No
		Organ / Tissue Donation:	☐ Yes ☐ No

NURSE'S INITIALS

ORIENTATION

ORIENTED TO:

☐ Room ☐ Bed ☐ Phone ☐ Call Light / TV ☐ Safety ☐ Bathroom Call Light ☐ Visiting Hours ☐ Smoking Policy
☐ Restraint Patient Education
☐ Unable to Orient / Reason:
☐ Patient reminded to retain no more than $5.00 at bedside.

NURSES INITIALS

PHYSICAL ASSESSMENT *(Must be completed by an RN)*
NEUROLOGICAL

Consciousness: ☐ Alert ☐ Lethargic **Oriented To:** ☐ Person ☐ Place ☐ Time
Responds Appropriately to Questions: ☐ Yes ☐ No Explain: _____
Speech: ☐ Clear ☐ Slurred ☐ Aphasic Explain: _____
Pupils: ☐ Equal ☐ React Equally Unequal: ☐ R > L ☐ L > R
Moves All Extremities Equally: ☐ Yes ☐ No Explain: _____
Strength of All Extremities: ☐ Strong ☐ Weak ☐ Absent

RN'S INITIALS

CARDIO-PULMONARY

Respiratory Effort: ☐ Easy ☐ Labored
Cough: ☐ None ☐ Yes **Sputum:** ☐ Yes ☐ No Color: _____
Breath Sounds: _____
Apical Pulse: Rate: _____ Rhythm: _____ **Pedal Pulse:** R: _____ L: _____ Describe: _____
Capillary Refill: ☐ Not Applicable ☐ Brisk ☐ Sluggish

RN'S INITIALS

GASTROINTESTINAL / GENITOURINARY

Abdomen: ☐ Soft ☐ Non-tender ☐ Tender Location: _____
☐ Firm ☐ Non-distended ☐ Distended Girth: _____
Bowel Sounds: ☐ Present ☐ Absent
Bladder: ☐ Non-distended ☐ Distended ☐ Catheter
Ostomies: Type: _____ **Care:** ☐ Independent ☐ Needs Assistance

RN'S INITIALS

INTEGUMENTARY *(Braden Scale MUST be completed on Skin Assessment FLow Shet, Form 90-5936)*

Skin Color: ☐ Pink ☐ Ashen ☐ Mottled ☐ Jaundiced ☐ Pale ☐ Flushed ☐ Cyanotic
Temperature: ☐ Warm ☐ Cool ☐ Hot ☐ Cold / Clammy
Turgor: ☐ Resilient ☐ Tenting
Edema describe location and degree (1-4 +) _____
(Braden Scale MUST be completed on Skin Assessment Flow Sheet, Form 90-5936)

RN'S INITIALS

SUMMARY STATEMENT

REFERRALS:
☐ Case Management Date: _____ ☐ Discharge / Placement ☐ AD / LW ☐ Nutrition Date: _____
☐ Chaplain Date: _____ ☐ Diabetic Date: _____ ☐ PT / OT (Request from MD) Date: _____
☐ Psych (Request from MD) Date: _____ ☐ SLP Date: _____
☐ Skin / Wound Care Date: _____ ☐ Other: _____
Notify MD / PA / NP of Patient's Arrival: ☐ Yes Time: _____ Plan of Care: ☐ Yes
Unable to complete because: _____

RN Signature for Physical Assessment: _____ **Date & Time:** _____

RN'S INITIALS

INIT	SIGNATURE / TITLE	INIT	SIGNATURE / TITLE