Admission Screening Tool
Memorial Hospital

Date _____

Instructions: Answer the following questions as they relate to the patient. The answers help us plan and provide care. Leave blank any questions you are unsure A nurse will review this form with you after it is completed. Thank y

Name of person completing form _____ Legal gardian if other than parent _____

Relationship to patient ☐Parent ☐Self ☐Nurse Other: _____

IDCFS WARD ☐Yes ☐No

Workers name _____ phone _____

for medical consent contact _____ phone _____

Primary language/method of communication _____ Interpreter _____

List all persons living in household with patient

Name	Age	Relationship

_____
Person to contact at discharge

_____
Phone Number

_____
Mode of Transportation home

(RN Complete this column)

INFORMATION ABOUT PATIENT

1. State reason fof hospitalization: _____

Birth History _____

2. Previous Hospitalization ☐Yes ☐No Date _____

Where _____ reason _____

☐Chronic illness ☐Multiple ED visits ☐Multiple hospitalizations

3. What is the expected length of stay? ☐Less than 24 hours ☐1 Day ☐2-3 Days ☐4-5 Days ☐Over 5 day ☐Unknown

4. Recently exposed to any of the following:

Chicken Pox (within last 3 weeks)	☐Yes	No	Date: _____
Pertussis (within last 3 weeks)	☐Yes	No	Date: _____
Measles, Mumps, Rubella (within last 3 weeks)	☐Yes	No	Date: _____
Tuberculosis	☐Yes	No	Date: _____
Hepatitis A	☐Yes	No	Date: _____

Are immunizations up to date? ☐Yes ☐No

If no, please explain _____

Would you like information about immunizations? ☐Yes ☐No

5. Family involvement plans for hospitalization?

Will an adult be here	☐Yes	☐No
Day time	☐Yes	☐No
Over night	☐Yes	☐No
Any visitor restrictions	☐Yes	☐No

Please explain: _____

6. Any language, religious or cultural practices or restrictions that we need to know about to provide care?

☐Yes ☐No Describe _____

☐PMD

☐Kids Doc number given x 4649

Preadmission Labwork done ☐Yes ☐No

☐CBC ☐U/A ☐Sickling

☐BT ☐PT PTT: INR:

☐Pre+Post procedure routine explained

☐NPO instructions

Discharge Criteria

Isolation needed ☐Yes ☐No

Immunization Record Requested ☐Yes ☐No

Immunization Record Provided ☐Yes ☐No

Other known communicable disease / antibiotic resistant organisms:

☐Educational handouts given/reviewed

☐ Reviewed visitation policy

☐ Unit orientation/PT rights+responsibilities

☐ Social Service Notified with any visitation restrictions

☐ Security Notified 4222

Date: _____

Time: _____

Initial: _____

Consider referral to:

☐ Pastoral Care 4005

☐ Interpreter

☐ Social Work 4485

Date: _____

Time: _____

Initial: _____

☐ Referral Made

INFORMATION ABOUT PATIENT

[illegible]

7. Does your child use any of the following:

☐Walker	☐Wheel chair	☐Car Seat Type:______
☐Splints / Braces	☐Crutches	☐Cane
☐Hearing Aid ☐left ☐right	☐Oxygen	☐Eye glasses / Contacts
	☐Suction	☐Capped teeth / Braces Loose Teeth
	☐Tracheostomy	☐Ventilation

Do you have them with you? ☐Yes ☐No

☐ Car seat education needed
☐ Car seat needed
☐ Car seat protocol initiated *
remind parent to bring car seat to the hospital prior to discharge

8. Does your child have a venous port, central line or PICC line ☐Yes ☐No

Date placed ______________ Purpose ______________

Last dressing change ______________ Last flush ______________

9. Does your child have any allergies?

☐Yes ☐No Explain: ______________

☐ Allergies noted on medical record (chip)
☐ Pharmacy notified
☐ Clinical nutrition notified

10. Nutrition: Describe foods, diet, etc. ______________

a) Special diet / Fluid Restrictions	☐Yes	☐No	______________
b) Tube Feeding	☐Yes	☐No	NG, NJ, GT, GJ
c) TPN	☐Yes	☐No	
d) Any difficulty feeding/eating/swallowing	☐Yes	☐No	
e) Recent weight changes	☐Yes	☐No	______________

If "Yes" was answered, notify
☐ Clinical nutrition via CHIP
If "Yes" was answered to d consider referral
☐ Speech Therapy *

Date ______________
Time ______________
Initial ______________

11. List current medications ☐None

Drug	Dose	Frequency	How taken (pill, liquid, inhaled etc.)	Last dose/ Next dose due	Reason taken

☐ Meds sent home
☐ Meds sent to pharmacy
☐ Meds not brought in
☐ Other
☐ Allergies to drugs/reaction
☐ Education requested/provided

12. Pain history: Describe your child's previous pain experiences. ☐None

____

How does your child react to pain ______________

What works best to decrease or take away pain ______________

13. Is anyone in this child's home being hurt, hit threatened, frightened or neglected by anyone at home or in your life?
☐Yes ☐No

Consider referral to:
☐ Soc. Work referral x 4485
Date: ______________
Time: ______________
☐ Referral Made

14. Any other information that would help us give this child / familymore individualized care? ______________

15. Do you have any questions about why you are here, the planned procedure, or what to expect? ☐Yes ☐No

☐Information provided by RN
Referred to: ______________

The following questions are for ages infants-3yrs

Child is: ☐Sitting ☐Crawling ☐Walking ☐Toilet Training
Feeds Self: ☐Yes ☐No
Uses: ☐Cup ☐Bottle ☐Breast

☐Sleep Positioning Discussed
☐Handout given & reviewed

Sleeps in: ☐Bed ☐Crib ☐Other _____
Plays appropriately ☐Yes ☐No
Are there concerns regarding this childs development or functional ability? ☐Yes ☐No

Grade _____ School _____

Any special learning needs ☐Yes ☐No Explain _____

☐Reading ☐Writing ☐Hearing problem ☐Vision problem

Other Learning difficulties _____

Plays appropriately ☐Yes ☐No Hobbies _____

Extracurricular activites _____

Consider referral to:
☐ PT *
☐ OT *
☐ Child life
☐ School prog.
☐ Audiology *
☐ Speech *
☐ Other
* Requires physician order

Date: _____
Time: _____
Initial: _____
☐ Referral Made

Do you Smoke? ☐Yes ☐No
Will you have a problem not smoking in the hospital? ☐Yes ☐No
Do you drink beer, wine, other types of alcohol? ☐Yes ☐No

How Much _____ How often _____ How recently _____

Do you use other drugs? ☐Yes ☐No

What kind _____ How much _____ How often _____ How recently _____

Would you like any information about how these behaviors might affect your health?

Alcohol	☐Yes	☐No	☐ Information given
Drugs	☐Yes	☐No	☐ Information given
Sexual activity/ Multiple partners	☐Yes	☐No	☐ Information given
Auto Safety / Seat belt use	☐Yes	☐No	☐ Information given
Gang Membership	☐Yes	☐No	☐ Information given
Hand gun use	☐Yes	☐No	☐ Information given

☐ Smoking policy explained
☐ educational hand-outs given
Specify: _____

☐ Educational handouts reviewed

19. Is this child"s home equipped with functioning:

☐Running Water ☐Electricity ☐Heat / Type:
☐Hot Water ☐Smoke Detectors

Consider referral to:
☐ Social Work x4485

Date: _____
Time: _____
Initial: _____
☐ Referral Made

20. Has anyone in your household recently experienced
☐Major changes (home, job, divorce, separation, death, new school, sibling, moved, marriage, serious illness or injury)
☐Sadness / Depression ☐Thoughts about ending their life
☐Psychologic or behavior problems ☐None
Would you like to see a social worker during your stay? ☐Yes ☐No

Consider referral to:
☐ Pastoral Care 4005
☐ other

Date: _____
Time: _____
Initial: _____
☐ Referral Made

21. Does this child's household receive assistance from any of the following agencies:

☐Home Nursing: Agency Frequency
☐Rehab Services: Agency Frequency
☐P.T. ☐O.T. ☐Speech ☐Audiology
☐WIC ☐Early Intervention ☐Medical Supply
Has the patient received any of these services in the past? ☐Yes ☐No

Consider referral to:
☐ Case Manager

Date: _____
Time: _____
Initial: _____
☐ Referral Made

22. During hospitalization or at the time of discharge; will there be difficulty with any of the following?
☐ Coordination of pt care or work related responsibilities
☐ Financial concerns related to child's illness / hospitalization
☐ Child's educational needs ☐ Home Environment
☐ Getting to appointment ☐ Paying for medications ☐ No problems

Consider referral to:
☐ Case Manager

Date: _____
Time: _____
Initial: _____
☐ Referral Made

☐ IPFER initiated

_____
RN Signature / Date

DATE:	TIME:	TEMP:	P:	R:	B/P	HT.	WT	HC	ABD CIRC	ALLERGIES

HISTORY	ASSESSMENT	ADDITIONS/EXCEPTIONS
❑ Seizure ❑ Dizziness / loss of balance ❑ Muscle weakness / paralysis ❑ Fainting	**NEUROLOGICAL:** Normocephalic (infant: head circumference WNL, suture lines smooth, fontanels flat). PERL. Moves all extremities well, equal strength. Alert, oriented to time, place, and person. Infant: cry is normal pitch, normal response to surroundings. Responds to visual and auditory stimuli appropriately.	
❑ Cold, cough, congestion ❑ Fever, sore throat ❑ Runny nose	**EENT:** Eyes clear and without drainage. External ears without redness or complaints/ sign of pain. Nares patent bilaterally and without drainage. Adequate dentition for age. No oral lesions. Gag and swallow reflexes intact.	
❑ Rashes ❑ Wounds	**SKIN:** Color normal for patient's race. No unusual pigmentation. No rashes. No bruising, contusions, or abrasions. No decubuti. Mucous membranes moist, skin turgor normal, hydration adequate. Skin warm, dry and intact centrally, and peripherally.	
❑ Cough ❑ Fatigue ❑ Difficult breathing	**RESPIRATORY:** Breath sounds clear and equal in all lobes. Aeration good. Spontaneous respirations with easy / normal effort, no retractions, nasal flaring, or tracheal tugging. No assistive devices or oxygen required.	
❑ Irregular or rapid heart rate ❑ High / Low blood pressure ❑ Swelling of arms / legs / feet ❑ Heart Murmur ❑ Clotting / Bleeding Problems	**CARDIOVASCULAR:** Color pink and without cyanosis. Blood pressure WNL. No edema. Heart sounds normal, no murmur. Apical pulse strong, regular, and without arrhythmias. Peripheral pulses strong and equal in all extremities. Perfusion normal (capillary refill 3 seconds or <).	
❑ Muscle weakness / paralysis ❑ Numbness or tingling of arm / leg	**MUSCULOSKELETAL:** Normal coordination and gait. Absence of joint swelling and tenderness. Full ROM in all extremities. No gross muscular atrophy	
❑ Nausea ❑ Vomiting ❑ Constipation ❑ Diarrhea ❑ Blood in Stool	**GASTROINTESTINAL:** Abdomen soft and nontender to palpation. No distention. Bowel sounds active and normal. Liver not enlarged and nontender.	
❑ Painful urination ❑ Hematuria ❑ LMP	**GENITOURINARY** No problems with urination. Bladder not distended after urination. Urine clear and straw colored and without odor.	

Notes

RN Signature