Your Hospital's Logo Here

INFUSION TREATMENT CENTER
PATIENT ADMISSION
HISTORY & ASSESSMENT

PATIENT IDENTIFICATION

PATIENT NAME:	DATE:
ADMITTING DIAGNOSIS:	PRIMARY PHYSICIAN:
SCHEDULED TREATMENT:	ONCOLOGIST:
ALLERGIES:	DATE of LAST DOCTOR'S VISIT:

HEIGHT:	WEIGHT:	**VITAL SIGNS:**	T:	P:	R:	BP:	irregular v.s., document in notes

A. PATIENT RIGHTS / RESPONSIBILITIES Information given? ☐ YES ☐ NO **C.** HIPAA Information given? ☐ YES ☐ NO

B. Patient received information on ADVANCE DIRECTIVES? ☐ YES ☐ NO

COMMENTS:

PAST MEDICAL HISTORY

PAST SURGERIES (include dates)

Previous Blood Transfusion? ☐ YES ☐ NO Reaction? ☐ YES ☐ NO If "YES", describe:

Immunizations up-to-date? TETANUS: ☐ YES ☐ NO Date:_____ PNEUMONIA: ☐ YES ☐ NO Date:_____ FLU: ☐ YES ☐ NO Date:_____

DISEASE HISTORY

☐ BRONCHITIS	☐ HIGH BLOOD PRESSURE	☐ DIABETES	☐ HEPATITIS - TYPE _____
☐ EMPHYSEMA	☐ CHEST PAIN / M I	☐ BLADDER PROBLEMS	☐ ARTHRITIS
☐ ASTHMA	☐ STROKE	☐ GI PROBLEMS	☐ ALZHEIMER'S
☐ TUBERCULOSIS	☐ CHF	☐ THYROID PROBLEMS	☐ GLAUCOMA / CATARACTS
☐ MENINGITIS	☐ PACEMAKER	☐ CIRCULATION PROBLEMS	☐ Hx OF SEIZURES

☐ OTHER: _____

NEUROLOGICAL / PSYCHOSOCIAL INITIAL ASSESSMENT (must be completed by RN)

LOC:	☐ ALERT	☐ LETHARGIC				
Mental Status:	☐ ORIENTED	☐ DISORIENTED	☐ PERSON	☐ PLACE	☐ TIME	
Concept of Illness:	☐ UNDERSTANDS	☐ ACCEPTS	☐ DENIES	☐ ANXIOUS	☐ UNCONCERNED	☐ UNAWARE
Behavioral Pattern:	☐ COOPERATIVE	☐ RESTLESS	☐ COMBATIVE	☐ UNCOOPERATIVE		
Psychosocial:	☐ CALM	☐ FRIENDLY	☐ AGITATED	☐ WITHDRAWN	☐ ANXIETY	☐ OTHER
Pupils:	☐ P E R R L A	☐ UNEQUAL	☐ VISION BLURRED			
Vision:	☐ GLASSES	☐ CONTACTS	☐ BLIND ___ R	___ L		
Hearing:	☐ IMPAIRED ___ R	___ L	☐ DEAF ___ R	___ L		
Speech:	☐ NORMAL	☐ SLURRED	☐ ASPHIA			
Sensory:	☐ INTACT	☐ NUMBNESS	☐ TINGLING			
Sleep Problems:	☐ NO	☐ YES (describe)	_____			

☐ **NOT FULLY ASSESSED (provide reason):** _____

PART OF THE MEDICAL RECORD

CARDIOVASCULAR

Rhythm: ☐ REGULAR ☐ IRREGULAR ☐ MURMUR

Peripheral Pulses: ☐ EQUAL ☐ UNEQUAL ☐ ABSENT ☐ STRONG ☐ WEAK ☐ BOUNDING

Edema: ☐ NONE ☐ PRESENT (Location): _____

_____

RESPIRATORY

Quality of Respirations: ☐ REGULAR ☐ IRREGULAR ☐ DYSPNEA ☐ SHALLOW

Cough: ☐ ABSENT ☐ PRODUCTIVE ☐ NON-PRODUCTIVE

Sputum: ☐ NONE ☐ CLEAR ☐ WHITE ☐ GREEN ☐ RUSTY ☐ YELLOW
☐ SCANT ☐ MODERATE ☐ COPIOUS

R - Lung Assessment: ☐ CLEAR ☐ DIMINSHED ☐ RALES ☐ RONCHI ☐ WHEEZING ☐ STRIDOR

L - Lung Assessment: ☐ CLEAR ☐ DIMINSHED ☐ RALES ☐ RONCHI ☐ WHEEZING ☐ STRIDOR

SOB with exertion: ☐ YES ☐ NO **Tobacco Use:** ☐ YES ☐ NO Packs per day: _____ # of Yrs: _____

Smoking Cessation Information Given: ☐ YES ☐ NO

ELIMINATION

Abdomen: ☐ SOFT ☐ ROUNDED ☐ FIRM ☐ DISTENDED ☐ TENDER

Bowel Sounds: ☐ NORMAL ☐ ABSENT ☐ HYPOACTIVE ☐ HYPERACTIVE

Bowel Elimination: ☐ CONSTIPATION ☐ DIARRHEA ☐ INCONTINENT ☐ OSTOMY last bowel movement: _____

Urinary Elimination: ☐ FREQUENCY ☐ BURNING ☐ URGENCY ☐ HEMATURIA ☐ DYSURIA
☐ HESITANCY

Foley Catheter: ☐ YES ☐ NO

REPRODUCTIVE / SEXUALITY

FEMALE:

LMP: _____

Pregnancy Possible: ☐ YES ☐ NO

Birth Control / Hormonal Therapy: ☐ YES ☐ NO

Breast Self-Exam: ☐ YES ☐ NO

Regular Pap Smears: ☐ YES ☐ NO

Mammogram: ☐ YES ☐ NO

MALE:

Testicular Self-Exam: ☐ YES ☐ NO

Prostate Cancer Screen: ☐ YES ☐ NO

PATIENT: Wants Information on Preventative Screening:
☐ YES ☐ NO (if "Yes", describe below)

_____

NUTRITION

Current Diet: _____ **Last time you ate or drank:** _____

Weight Change in the Past 6 Months: ☐ YES ☐ NO **Amount GAINED:** _____ **Amount LOST:** _____

Mucous Membranes: ☐ MOIST ☐ DRY ☐ LESIONS

Difficulty Swallowing: ☐ YES ☐ NO **Difficulty Chewing:** ☐ YES ☐ NO

Nausea / Vomiting > 3 Days: ☐ YES ☐ NO **Tube Feeding:** ☐ YES ☐ NO

Questions about Diet: ☐ YES ☐ NO **If "Yes", is a Dietary Consult Needed:** ☐ YES ☐ NO

Do you have any Religious, Cultural or Personal Dietary Preferences: ☐ YES ☐ NO

If "Yes", describe: _____

_____

_____

LIFE STYLE

Alcohol: Amount: _____ Date Last Used: _____ ☐ DENIES ALCOHOL USE

Drugs: Type (Cocaine, Heroin, etc.): _____ Date Last Used: _____ ☐ DENIES DRUG ABUSE

PART OF THE MEDICAL RECORD

Your Hospital's Logo Here

INFUSION TREATMENT CENTER
PATIENT ADMISSION
HISTORY & ASSESSMENT

PATIENT IDENTIFICATION

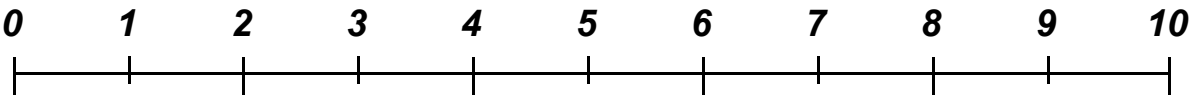
PAIN ASSESSMENT

ACUTE PAIN: ☐ NO ACUTE PAIN	CHRONIC PAIN: ☐ NO CHRONIC PAIN
LOCATION:	LOCATION:
INTENSITY: SCALE:	INTENSITY: SCALE:
COMFORT GOAL:	COMFORT GOAL:
QUALITY (Patient's Own Words):	QUALITY (Patient's Own Words):
ONSET: PATTERN:	ONSET: PATTERN:
AGGREVATING FACTORS:	AGGREVATING FACTORS:
ALLEVIATING FACTORS:	ALLEVIATING FACTORS:
IMPACT / Functional Ability:	IMPACT / Functional Ability:
IMPACT / Quality of Life:	IMPACT / Quality of Life:
PAIN MGMNT HISTORY / Helpful:	PAIN MGMNT HISTORY / Helpful:
PAIN MGMNT HISTORY / Not Helpful:	PAIN MGMNT HISTORY / Not Helpful:

PAIN SCALES:

WONG-BAKER: *(Faces)*

0 - 10 VISUAL: *(Numeric)*



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

WONG-BAKER FACES PAIN SCALE from Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Ahmann E, DiVito-Thomas PA, Whaley & Wong: Care of Infants & Children, 6th ed, St. Louis, MO: Mosby-Year Book Inc., 1999; 1153. Copyrighted by Mosby-Year Book, Inc. Reprinted with Permission.

NON-COGNITIVE: *(FLACC Scale)* →

SEDATION SCALE:

S = NORMAL SLEEP, EASY TO AROUSE, ORIENTED WHEN AWAKENED, APPROPRIATE COGNITIVE BEHAVIOR
1 = WIDE AWAKE - ALERT (OR AT BASELINE), ORIENTED, INITIATES CONVERSATION
2 = DROWSY, EASY TO AROUSE, BUT ORIENTED AND DEMONSTRATES APPROPRIATE COGNITIVE BEHAVIOR WHEN AWAKE
3 = DROWSY, SOMEWHAT DIFFICULT TO AROUSE, BUT ORIENTED WHEN AWAKE
4 = DIFFICULT TO AROUSE, CONFUSED, NOT ORIENTED
5 = UNAROUSABLE

INTERVENTION:

1 = DISCUSS PAIN MANAGEMENT PLAN WITH PHYSICIAN
2 = PHARMACOLOGICAL (See MED KARDEX)
3 = NON-PHARMACOLOGICAL **A.** Position Changed **B.** Relaxation Technique **C.** Splinting **D.** Imagery **E.** Music **F.** Education **G.** Other: _____

FLACC PAIN SCALE:

1. Sum of Face, Legs, Activity, Cry & Consolability Scores = FLACC Score
2. Record FLACC Score using the 0-10 NUMERIC Scale above.

_____ = FACE Score
0 = No particular expression or smile
1 = Occasional grimace or frown, withdrawn, disinterested
2 = Frequent to constant frown, clenched jaw, quivering chin

_____ = LEGS Score
0 = Normal position, or relaxed
1 = Uneasy, restless, tense
2 = Kicking, or legs drawn up

_____ = ACTIVITY Score
0 = Lying quietly, normal position, moves easily
1 = Squirming, shifting back & forth, tense
2 = Arched, rigid, or jerking

_____ = CRY Score
0 = No crying (asleep or awake)
1 = Moans or whimpers, occasional complaint
2 = Crying steadily, screams or sobs, frequent complaints

_____ = CONSOLABILITY Score
0 = Content, relaxed
1 = Reassured by touching/hugging/talking to, distractable
2 = Difficult to console or comfort

PART OF THE MEDICAL RECORD

ACTIVITY:

Mobility: ☐ INDEPENDENT ☐ UNSTEADY ☐ WEAKNESS ☐ PARALYSIS

Devices: ☐ CANE ☐ CRUTCHES ☐ WALKER ☐ WHEELCHAIR ☐ BRACE ☐ OTHER

Type of Prosthesis: _____

DUE TO THE INCREASE IN DOMESTIC VIOLENCE, WE ASK ALL PATIENTS

Are you being hurt, hit or frightened by anyone in your life? ☐ YES ☐ NO

If "Yes", describe: _____

Would you like assistance in dealing with this problem? ☐ YES ☐ NO

Assessment data obtained from: ☐ PATIENT ☐ SIGNIFICANT OTHER _____

ADDITIONAL COMMENTS

PART OF THE MEDICAL RECORD