UNIVERSITY MEDICAL CENTER

ADMISSION PROFILE

AFFIX PATIENT INFO LABEL HERE

Patient Name ______________________ MR# ____________

Date ____________________

Valuable	N/A	Sent Home	Placed in Safe	Remains at Bedside	Valuable	N/A	Sent Home	Placed in Safe	Remains at Bedside
Cane/Walker					Hearing Aid				
Dentures					Clothing				
Eyeglasses					Other:				

Valuables: *I fully understand that HUMC is not responsible for any personal property brought in or retained at the bedside at anytime. I fully understand that HUMC provides a safe for my valuable(s) should I wish to place them there for the duration of my hospital stay.*

____ ____

Signature of Patient/Significant Other *Witness*

Section 1 - General Information

Information obtained from: ❒ Patient ❒ Family/Significant Other

Reason for Admission / Chief Complaint: ______________________________

Transferred from / Admitted From: ❒ Home ❒ Homeless ❒ Other / Facility Name: ______________________

ALLERGIES: ❒ Denies ❒ Latex ❒ Contrast Dye ❒ Food: ______________________

❒ Medications: ______________________________

❒ Other: ______________________________

Explain Reaction: ______________________________

____

Advance Directive:

❒ No ❒ Yes, Copy on Chart ❒ Yes, Copy Requested from: ❒ *Patient/Family* ❒ *Physician* ❒ *Medical Records*

❒ Information Requested ❒ Information Given

Emergency Contact This Admission:

______________________ ______________ ______________ ______________

Name *Relationship* *Home #* *Work #*

❒ Understands English ❒ Speaks English ❒ Reads English ❒ Interpreter Required ❒ Primary Language ______________
(if other than English)

Immunization Status:

If 50 or older, date of last Flu Vaccine ____________ ❒ Never received ❒ Unable to recall

If 65 or older, date of Pneumococcal Vaccine ____________ ❒ Never received ❒ Unable to recall

If patient states they never received vaccines or they are unable to recall, give appropriate Vaccine Information Sheet and initiate influenza and/or pneumococcal vaccine standing orders on discharge. **Not Applicable for Bone Marrow or Organ Transplant Patients**

Infectious Disease History: ❒ Denies ❒ T.B. ❒ Other: ______________________________

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Section 2 - Health History

Pertinent Medical / Surgical History: ☐ No ____

____

____

____

Patient Admitted with a Pressure Ulcer: ☐ Yes ☐ No If yes, document on the Pressure Ulcer Documentation Record

Outpatient Services: ☐ No ☐ Dialysis ☐ Radiation Oncology ☐ Cancer Center

Other: ____

Anesthesia History: ☐ Uneventful ☐ Other: ______________________________

Section 3 - Cognitive/Sensory Perception

Vision: ☐ No difficulty reported ☐ Impaired: ______________ ☐ Glasses ☐ Contacts ☐ Other: ______________

Hearing: Do you have difficulty hearing even when a speaker faces you and speaks louder? ☐ Yes ☐ No

If yes, complete Form #5013811 and obtain an assistive listening device from Distribution

Hearing Aids ☐ In Use ☐ Left Home ☐ Not Working If not working change battery (available in Distribution)

or refer to family/significant other.

Section 4 - Pain History Assessment

PAIN INTENSITY SCALE – 0 - 10

0	1-3	4-7	8-10
None	Mild	Moderate	Severe

Pain Scale for Non-Communicative Patient

1 - 2 Sleeping, calm / relaxed, not agitated
3 - 4 Grimacing with movement
5 - 6 Moaning with movement
7 - 8 Restless
9 - 10 Constant moaning without stimuli

Do you have pain now? ☐ Yes ☐ No Intensity: __________ Describe: ______________________________

What is an acceptable level of pain to you in order to continue your activities of daily living? ______________

If current pain intensity is > 4 or higher than patient's acceptable level of pain, continue with pain assessment on flowsheet.

Patient Name ______________________ MR# __________

Section 5 - Psychosocial

Tobacco: ❒ Yes ❒ No How Long?: __________ Type: __________ Amount: __________

Have you smoked or has someone in your house smoked in the last year? ❒ Yes ❒ No If yes, would you like:

❒ Information on Smoking Cessation (Carenotes) ❒ Referral to a Smoking Cessation Program/Counseling (ext. 8908) ❒ Patient Refused

Alcohol: ❒ Yes ❒ No Do you drink every day? ❒ Yes ❒ No If no, how often? __________

Amount of drinks per day: __________ Last Drink: __________

Emotional Illness: ❒ Yes ❒ No Dx: __________

Illicit Drug Use: ❒ Yes ❒ No Type: __________ Last Use: __________

Are you currently in a **physical or emotionally abusive** relationship? ❒ Yes ❒ No Specify: __________

If yes to Daily Alcohol, Emotional Illness, Illicit Drug Use, or Physical / Emotional Abuse refer to Social Service Ext. 2110

❒ Referral Called: __________

Do you have any special needs we should be aware of? __________ ❒ None Requested

Cultural needs/considerations affecting hospitalization and plan of care: __________ ❒ None Requested

Spiritual resources requested (Ext. 2345): __________ ❒ None Requested

Section 6 - Depression Screen

In the past month have you been bothered a lot by:

❑ Trouble sleeping (# ______ hours slept per night)
❑ Little interest or pleasure in doing things
❑ Feeling down, depressed or hopeless
❑ "Nerves" or feeling anxious or on the edge
❑ Worrying about a lot of different things

- If the patient has **2** or **3** of the above symptoms, discuss the plan of care to address these issues with the primary physician.
- If the patient has **4** or **5** symptoms, or answers that he/she is feeling down, depressed, or hopeless, ask the patient, **"Do you have thoughts of harming yourself?"**

Select the patient's answer below:

❑ Patient denies thoughts of harming self
❑ Patient states YES to thoughts of harming self

- If the patient answers **YES,** ask: **"What would you do to harm yourself?"**

Select answer below:

❑ Thoughts of harming self but denies intent
❑ Thoughts of harming self and has intent

- If **YES** to either question:

– Initiate 1:1 arms length observation monitoring and notify doctor immediately and request he/she call for psychiatric consultation **(Ext. 3535)**
– Initiate Protocol for Care of Patient who is High Risk for Suicide, Self Injury, Violence Toward Others and or Property.

Section 7 - Teaching

Readiness to Learn: ❒ Yes ❒ No

Preferred Learning Style	Potential Barriers to Learning	Learning Needs
❒ Visual	❒ None ❒ Emotional	❒ Diagnosis ❒ Safe Use of Equipment
❒ Written	❒ Desire/Motivation ❒ Cultural	❒ Medications ❒ Community Resources
❒ Demonstration	❒ Physical Limitations ❒ Spiritual	❒ Nutrition/Diet
❒ Learning Deficiency: __________	❒ Limited Learning Ability ❒ Religious	❒ Self Care Needs / Management
❒ Other __________		❒ Other: __________

Sections 1-7 Completed By: ______________________ **Date/Time:** __________

Signature *Title*

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Section 8 - Activity / Safety

Hendrich Fall Risk Model - Assessment Tool **Score ≥3 Refer to Fall/Injury Prevention Protocol for High Risk Interventions**

Risk Factors	Points
Recent History of Falls	+7 PT eval/screen
Depression	+4
Altered Elimination	+3
Confusion/Disorientation	+3

Risk Factors (contd.)	Points
Dizziness/Vertigo	+3 PT eval/screen
Poor Judgement	+3
Poor Mobility/Generalized Weakness	+2
TOTAL INITIAL RISK SCORE	

KEY	
0 - 2	Normal/Low Risk
3 - 6	Level 1/High Risk
More than 6 PT eval/screen	Level 2/Extremely High Risk

PERFORMANCE OF ADL

Trouble feeding self/opening jars and containers ❒ Yes ❒ No

Difficulty with Dressing ❒ Yes ❒ No

Difficulty with Personal Hygiene ❒ Yes ❒ No

If yes to any of the above questions is a change from the pre-admission level then enter OT Eval/Screen into IDX Order # ____________________

Unsteady gait / balance ❒ Yes ❒ No

Use of Assistive Devices / Prosthetics ❒ Yes ❒ No

If yes to either of the above questions: PT Eval / Screen entered into IDX Order # ____________________

Section 9 - Nutrition

❒ Special Diet at Home ____________________

Would you like information about your diet? ❒ Yes ❒ No

If **YES, enter CONSULT for Nutrition Education in IDX Order#:** ____________________

High Nutrition Risk Criteria

ANY HIGH RISK DIAGNOSIS OR YES ANSWER TO THE QUESTIONS BELOW INDICATES HIGH NUTRITION RISK AND REQUIRES REFERRAL VIA THE IDX-LASTWORD SYSTEM

High Risk Diagnosis & Current Physical Findings:

❒ Breast Feeding/Pregnancy not on maternity units
If yes also contact Pharmacy

❒ Renal Failure

❒ Dysphagia

❒ Homeless

❒ Other ____________________

❒ Supplements (i.e., Ensure) / Tube Feed / TPN ____________

❒ Newly diagnosed Diabetes

❒ Pressure Ulcer - Stage II or greater

❒ Dehydration

❒ Eating Disorder

Weight History

Actual Weight __________ Stated Weight __________ Stated Height __________

Unintentional weight change > 10 lbs. in last 3 months? ❒ Yes ❒ No ______ lbs. In ______ Months

Reason: ____________________

Reduce intake (less than 1/2 of usual for last 5 days) ❒ Yes ❒ No Diarrhea (> 3 days) ❒ Yes ❒ No

Vomiting (> 3 days) ❒ Yes ❒ No

Referral for High Nutritional Risk entered into IDX? ❒ **Yes** ❒ **No** **Order#** ____________________

Section 10 - Initial Discharge Assessment - Ext. 2299

Refer to case management if home environment is inconsistent with patient's needs or patient required services prior to admission or there is concern with home environment supporting safe patient care.

Previous Home Care Services: ❒ Yes ❒ No Does patient live alone? ❒ Yes ❒ No

If yes to either question, refer to Case Management

Referral? ❒ Yes ❒ None Required

Sections 8-10 Completed By: ____________________ **Date/Time:** ____________
Signature *Title*