ADULT
ADMISSION ASSESSMENT

Date_____ Time_____ Addressograph

Person to Notify in Case of Emergency:
Name_____
Phone _____
Relationship _____

Orientation to Nursing Unit:
Nurse Call System ( )
Crib / Side Rails ( )
Bathroom ( )
Phone ( )
No Smoking ( )
No leaving children unattended ( )
Bed Controls ( )
ID Bracelet ( )
TV Controls ( )
Visiting Hours ( )
Patient Information ( )

Questions for Patient:

	Yes	No
*Advanced Directives		
Durable POA		
Healthcare Surrogate		
*Organ Donor		
Patient Rights Information Reviewed		
Patient Voice Understanding of Above		
*If no, information given		

Admitted from:
Home ( ) ER ( )
Swingbed ( ) Surgery ( )
Nursing Home ( ) MD Office ( )

Admitted via:
Stretcher ( ) Ambulatory ( )
Wheelchair ( ) Parent's Arms ( )

Chief Complaint: _____
_____

Vital Signs: Temp_____ Pulse _____ Has received tx for this condition prior to admission ( ) Yes ( ) No
Resp _____ B/P_____ If yes, explain: _____

Disposition of Valuables

Caldwell County Hospital will not assume responsibility for lost or damaged valuables, clothing, or personal items kept in the patient's possession. Valuables should be taken home or secured by the hospital.

( ) Valuables taken home ( ) Valuables secured by hospital* ( ) No valuables with patient
*See valuables envelope for description. Envelope # _____
Patient / Family Signature _____
Witness Signature _____
Date_____ Time _____

Valuables picked up by _____

Witness _____Date / Time _____

Health Profile: Informant: ( ) Patient ( ) Other_____

Disposition of Medication: ( ) Left at Home ( ) Stored at Nurses Station ( ) At Bedside
Sent home with _____

Have you been hospitalized at our facility in the past 7 days? ( ) Yes* ( ) No
***If yes, has there been any changes in your status since last admission? ( ) Yes* ( ) No**
***If yes, COMPLETE ASSESSMENT; if no, copy previous assessment and attach to this assessment.**

Rev. 1/05

Medical History and Previous Surgery: ( ) Heart ( ) Diabetes ( ) Seizures ( ) HTN ( ) GI
( ) Thyroid ( ) Neuro ( ) EENT ( ) Musculoskeletal ( ) Cancer ( ) GU ( ) Pulmonary / Respiratory
( ) Vascular ( ) Psychological / Mental
Explain _____

_____

Ever had a blood transfusion? ( ) Yes* ( ) No *If yes, when: _____

Social / Environmental Assessment:

1. Patient lives: ( ) Alone ( ) With family ( ) At home ( ) Nsg home ( ) With S/O
2. Habits: ( ) Tobacco _____
   ( ) Alcohol _____
   ( ) Recreational Drugs _____
3. Education: Last grade in school attended: (please circle)
   1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 5+
   Can read? ( ) Yes ( ) No
   Can write? ( ) Yes ( ) No
4. Is Home Health involved in your Care? ( ) Yes ( ) No
5. Abuse / Neglect / Exploitation Screen

Yes	No	Questions
( )	( )	Do you feel unsafe in your home?
( )	( )	Are you afraid of anyone?
( )	( )	Have you ever been physically, sexually or emotionally abused?
( )	( )	Within the past year, have you ever been hit, slapped, kicked, or otherwise physically hurt?
( )	( )	Have you ever been touched in a manner that makes you feel uncomfortable?

Yes	No	Observations
( )	( )	Evidence of neglect by self?
( )	( )	Evidence of neglect by caretakers?
( )	( )	Evidence of abuse by self or others?

If yes is checked on any of the above items, consult Police, Social Services and notify the MD.

Social Services Contact: _____ Time: _____

Physical Assessment (Must be completed by an RN)

Skin

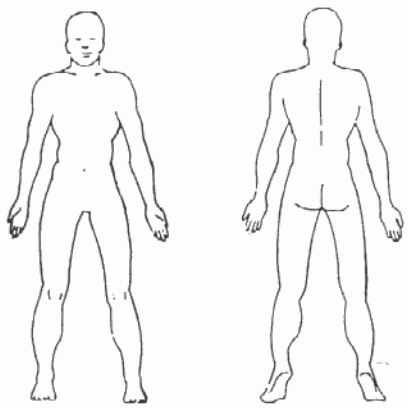
Color Impairment: ( ) None ( ) Pallor
( ) Flushed ( ) Cyanosis ( ) Jaundice
( ) Other _____
Temperature: ( ) Warm ( ) Hot ( ) Cool
Turgor: ( ) Good ( ) Fair ( ) Poor
Impairment of Skin: ( ) Yes* ( ) No
*If yes, describe / mark location on diagrams:

_____

_____

_____

SKIN ASSESSMENT:



Oral / Dental / Nasal

Teeth Condition: ( ) Good ( ) Fair ( ) Poor ( ) N/A
Dentures: ( ) Upper ( ) Lower ( ) Partial ( ) Complete
( ) With Patient ( ) Not with Patient
Gums: ( ) Pink ( ) Pale ( ) Inflamed ( ) Bleeding
( ) Moist ( ) Dry
Nose: ( ) Nosebleeds ( ) Drainage ( ) No problems
Describe _____

Hygiene

Bathing: ( ) Minimal Assist ( ) Partial Assist ( ) Complete
Condition on arrival: _____
Oral Hygiene: ( ) Self ( ) Assist ( ) Complete Condition on arrival: _____
Hair Condition: _____

Neuro Status

( ) Conscious ( ) Semiconscious ( ) Unconscious

( ) Alert ( ) Oriented to: ( ) Person ( ) Place ( ) Time

Weakness / Paralysis: ( ) None ( ) Left Arm ( ) Right Arm ( ) Left Leg ( ) Right Leg

Range of Motion: ( ) Independent ( ) Requires Assistance

Pupils / Eyes

Pupils: ( ) Equal ( ) Unequal: R < L or L < R ( ) Reactive ( ) Nonreactive: R L

Eyes: ( ) Drainage: R L Describe:_____

Vision

( ) Adequate ( ) Decreased: R L ( ) Blind: R L ( ) Cataracts: R L ( ) Prosthesis: R L

( ) Glasses / Contacts: ( ) With Patient ( ) Not with Patient

Speech / Swallowing

Speech: ( ) Clear ( ) Easily Understood ( ) Slurred ( ) Partially Understandable

( ) Cannot be Understood

Swallows: ( ) Without Difficulty ( ) With Difficulty ( ) Chokes on Saliva ( ) Chokes on Liquids

( ) Chokes on Solids

Hearing / Ears

Hearing: ( ) Adequate ( ) Decreased: R L ( ) Hearing Aid: R L ( ) With Patient

( ) Deaf: R L ( ) Uses Sign Language ( ) Reads Lips ( ) Communicates through writing

Ears: Drainage: R L Describe:_____

Mobility

( ) Independent ( ) Needs Minimal Assist ( ) Needs Significant Assist ( ) Requires Total Assist

( ) Uses Crutches ( ) Uses Walker ( ) Uses Wheelchair ( ) Uses Cane

( ) With Patient ( ) Not with Patient

( ) Uses Limb Prosthesis ( ) With Patient ( ) Not with Patient

Respiratory / Cardiovascular

Respiratory Problems: ( ) None ( ) Wheezing ( ) Stridor ( ) Dyspnea ( ) Hemoptysis

( ) Cough ( ) Nonproductive ( ) Productive Describe:_____

Duration: _____

( ) Dyspnea ( ) Exertional ( ) At Rest

( ) Irregular Breathing Pattern: _____

Breath Sounds:_____

Aids to Respiration: ( ) None ( ) Oxygen at Home: Amt. / Del. Method _____

Neb Txs at Home ( ) Suctioning ( ) Tracheostomy ( ) Other _____

Cardiovascular Problems: ( ) None ( ) Chest Pain - Frequency / Duration / Precipitating & Alleviating Factors:

_____

( ) Cyanosis ( ) JVD ( ) Irregular Pulse / Rhythm Other _____

Cardiovascular Aids: ( ) Pacemaker: ( ) Demand ( ) Fixed Rate

( ) Implanted Defibrillator ( ) Other_____

Elimination

Bowel Status:

Bowel Sounds:	LUQ	RUQ	LLQ	RLQ
Present				
Absent				
Hyperactive				
Hypoactive				

Frequency of BM: ( ) Daily ( ) BID ( ) QOD Other: _____

( ) Formed Stool ( ) Constipation ( ) Diarrhea: Color: _____

Date of last BM: _____

Bowel Problems: ( ) None ( ) Pain ( ) Flatulence ( ) Change in Bowel Habits

( ) Bloody Stools ( ) Rectal Drainage ( ) Incontinence ( ) Hemorrhoids ( ) Other _____

Abdomen: ( ) Soft ( ) Firm ( ) Tender ( ) Non-Tender ( ) Distended ( ) Non-Distended

Urinary Status:

Problems: ( ) None ( ) Cloudy Urine ( ) Foul Smell ( ) Dysuria ( ) Hematuria ( ) Nocturia

( ) Incontinence ( ) Stress ( ) Constant ( ) Urgency / Frequency ( ) Retention ( ) Burning

( ) Pain Other:_____

( ) Ostomy ( ) Self Cath: Frequency_____

( ) Indwelling Foley - date last changed: _____ ( ) Palpable Bladder

GU

Female

Currently Pregnant: ( ) Yes ( ) No ( ) NA

( ) Menses Problems:_____

_____

Date of last Menstrual Period:_____

_____

( ) Vaginal Discharge:_____

Male

( ) Prostate Problems

( ) Problems establishing Urine Stream

( ) Penile Discharge: _____

( ) Hx STDs:_____

Other: Male / Female:_____

Comfort / Rest / Sleep

Sleep

( ) No Problems ( ) Awakens Frequently ( ) Unable to Fall Asleep Easily

( ) Requires Sleeping Medication - Med / Dose / Frequency _____

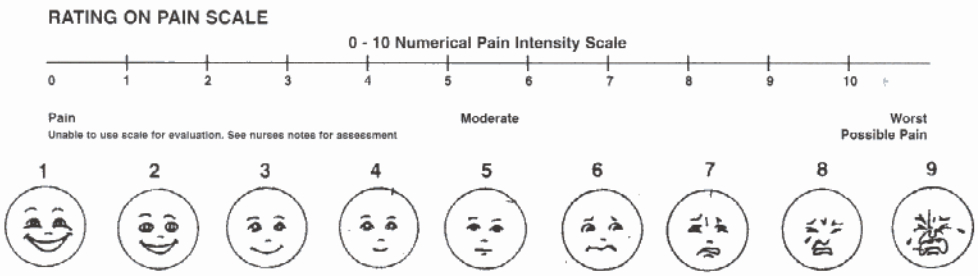
Avg. # Hrs. Slept Each Night _____ # Pillows used _____

Comfort / Pain

Is the patient currently having pain or admitted with a pain related diagnosis? ( ) Yes ( ) No

If yes, complete this section.

Intensity (circle appropriate pain intensity level)



Location: _____

Duration: _____ ( ) Continuous ( ) Intermittent

( ) Chronic - > 6 months ( ) Acute - < 6 months

Type: ( ) Ache ( ) Sharp ( ) Dull ( ) Shooting ( ) Stabbing ( ) Burning ( ) Pressure

( ) Cramping ( ) Other:_____

Relieved by: ( ) Rest ( ) Heat ( ) Cold ( ) Position ( ) Activity

( ) Meds:_____ ( ) Other: _____

Aggravated by: _____

Do you have any personal, cultural, spiritual and/or ethnic beliefs that may affect the way your pain is treated?

( ) Yes ( ) No If yes, explain: _____

_____

Psychological Status

Body Image / Self Concept Problems: ( ) None Identified at this time ( ) Signs / Symptoms of Depression

( ) Suicidal Ideations ( ) Other: _____

Observation of Patient Behavior / Interaction: ( ) Cooperative ( ) Anxious ( ) Withdrawn ( ) Restless

( ) Calm ( ) Uncooperative ( ) Unresponsive

Spiritual Needs: ( ) Yes ( ) No Requests Minister, etc. be notified: ( ) Yes ( ) No

Minister's Name / Phone No._____

Discharge Needs

( ) Housing ( ) Physical Care ( ) Housekeeping ( ) Meals ( ) Finances ( ) Transportation

( ) Home Health ( ) Nursing Home Placement ( ) None Identified at this time

( ) Discharge Planner Notified

Plan of Care Reviewed with:

( ) Patient ( ) Family ( ) Significant Other

Other Notes: _____

Signature / Title of Nurse Collecting Data

Date / Time

Signature / Title of Nurse Performing Assessment

Date / Time

FALL RISK ASSESSMENT

	SCORE	
Confused, disoriented, hallucinating, combative	20	
Unstable gait, weakness	20	
Hx of syncope, seizures, postural hypotension	20	
Recent hx of falls	20	
Use of restraints	20	
Paralysis, hemiplegia, stroke, TIA	15	
Post-op condition, sedated	10	
Impaired vision	10	
Drug or alcohol withdrawal	10	
Use of walker, cane (other assistive aids)	10	
Narcotics, diuretics, antihypertensives, hypnotics, tranquils, poly-pharmacy (more than 5 scheduled meds)	10	
Bowel, bladder urgency, incontinent	10	
Equipment with risk for entanglement (IV's, O2, feeding tubes, etc.)	10	
Age 70 or above	10	
Age 12 or below	5	
Language barrier	5	
Poor hearing	5	
SCORE		
High Risk Interventions Implemented (Initial)		

A score of **35** or above may indicate the patient is at high risk for falling. These patients at high risk for fall shall have the following interventions implemented. Nursing shall monitor these at least every 2 hours.

- Visually observe patient every 2 hours. If awake, offer comfort measures and toileting.
- Instruct patient and/or family to ask for assistance for any patient activities.
- All items for patient's use will be within easy reach.
- Reassess for safe footwear.
- Reinforce use of assistive devices, if used.
- Reassess for a clutter free, well-lit environment.
- Re-orient and repetitively reinforce use of call bell. Ensure it is within reach.
- Consider a room closer to the nursing station.
- Utilize the Bed Check Alarm System / chair alarms.
- Utilize high-risk identification including green dots on wristband, door chart and near room number on the nurse call system.

Date:_____ Height:_____ Weight:_____

Allergies (Medications, OTCs, Food, Environmental) & Type of Reaction:

	Pregnant? ( ) Yes ( ) No
	EDC_____
	Lactating? ( ) Yes ( ) No

Current Medications / Herbs / Vitamins / OTC Meds	Dose	Frequency	Last Dose

Date:_____

Physical Therapy Screen

Within the last 7 days, functional status has changed resulting in an inability to complete: ☐ ADLs ☐ Transfers ☐ Ambulation independently or with minimal assistance.

Date:_____

Nutritional Screen

Special diet at home:_____

Dietary likes / dislikes:_____

☐ Weight change of 20 lbs. in past 3 months ☐ NOP > 24 hours
☐ Obesity > 300 lbs.
☐ Hasn't eaten for more than 2 days ☐ Loss of appetite
☐ Altered taste sensation
☐ Special dietary restrictions ☐ Hx of > one major chronic illness
☐ Difficulty Swallowing ☐ Excessive Thirst ☐ Nausea / Vomiting
☐ Hematuria / Hematoemesis ☐ Persistent Diarrhea ☐ Pregnant / Lactating
☐ Cultural, Ethnic, Religious Food Preferences_____

Date:_____

Speech Screen

Speech: ☐ Clear ☐ Easily Understood ☐ Slurred ☐ Partially Understandable ☐ Cannot be Understood

Swallows: ☐ Without Difficulty ☐ With Difficulty ☐ Chokes on Saliva ☐ Chokes on Liquids ☐ Chokes on Solids

_____ _____

Nurse's Signature Date / Time

Addressograph - Send Copy to Pharmacy

Addressograph - Send Copy to P.T.

Addressograph - Send copy to Dietary

Addressograph - Send copy to Speech