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ADMISSION DATA BASE

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For In & Out Surgery Patients, complete shaded areas

PATIENT IDENTIFICATION

INITIAL NURSING ASSESSMENT

Arrived From: ☐ Home ☐ Nursing Home ☐ ER-see ER Triage Record ☐ ER-see ER Fax Report ☐ Physician's Office ☐ Surgical Services ☐ Other: _____

Date of Arrival: _____ Time of Arrival: _____ (Military Time)

Chief Complaint / History Present Illness: _____

Information Given by: _____

Past Med History: ☐ Heart Disease ☐ Hypertension ☐ Angina ☐ Hypotension ☐ Chest Pain ☐ Circulation ☐ Kidney/Bladder ☐ Cancer ☐ Diabetes ☐ Thyroid ☐ Anemia ☐ Seizures ☐ Stroke ☐ TB ☐ Lung Disease ☐ Glaucoma

Past Surgical History _____

Other (specify): _____

Inoculations: PPD ☐Y ☐N Date _____ Tetanus ☐Y ☐N Date _____ Flu ☐Y ☐N Date _____ Pneumonia ☐Y ☐N Date _____

Previous Anesthesia: ☐ Yes ☐ No **Difficulties with Anesthesia:** ☐ Yes ☐ No

If yes, specify _____ **Clinical Pathways Initiated:** ☐ Yes ☐ No

Adm VS: T _____ HR: _____ RR: _____ BP (R) _____ (L) _____ SaO2 (ASU) _____ Ht: _____ Wt: _____

NPO Status: _____ **Valuables:** **Belongings Log Completed:** ☐ Yes ☐ No

CURRENT MEDICATIONS

Name of Med ☐ No Medications	Dose / Schedule	Last Dose	Name of Med ☐ No Medications	Dose / Schedule	Last Dose

Disposition of Medication: ☐ N/A ☐ Home ☐ Given to Family ☐ Bedside ☐ Valuables Envelope

ALLERGIES

Drugs, Food, Environment: ☐ None Known ☐ Latex Allergy **Specify Reaction:**

PERSONAL & SOCIAL

Marital Status: _____ Occupation: _____ Role in Family: _____

Decision Maker: _____ Tel #: _____ Relationship: _____

Contact Person in event of emergency:

Name: _____ Relationship: _____ Phone (Day): _____ (Eve): _____

LIFE STYLE

☐ SMOKING - How many packs / day? _____ For how many years? _____ Smoking Cessation Information given? ☐Yes ☐No ☐N/A

☐ ALCOHOL - Amount _____ Date Last Used: _____ ☐ Denies alcohol use

☐ DRUGS - Type (Cocaine, Heroin, etc.) _____ Date Last Used: _____ ☐ Denies substance abuse

COPING / STRESS

Stress in your life (health, relationships, finances): _____

Recent changes / losses (job, move, new baby, divorce, death): _____

What do you do under stress? _____

Due to the increase in domestic violence, we ask all adult patients. "Are you being hurt, hit or frightened by anyone in your life?" ☐ Yes ☐ No

If yes, explain: _____

Would you like assistance in dealing with this problem? ☐ Yes ☐ No **If patient states "Yes", contact Social Services:** _____

☐ Patient denies ☐ Patient is unable to communicate ☐ Pamphlet given

BEHAVIOR ASSESSMENT

Previous Psychiatric Therapy / Counseling / Admissions: ☐ None _____

☐ Depression ☐ Self-Destructive Thoughts / Attempts ☐ HALLUCINATIONS: ☐ Auditory ☐ Visual ☐ Other ☐ Anxiety

SPIRITUAL CULTURAL

Do you have any spiritual or cultural practices than may affect your medical care or hospitalization? ☐ Yes ☐ No

If yes, explain: _____

ADVANCED DIRECTIVES

Do you have **Advanced Directives?** ☐ Yes ☐ No Copy placed on chart? ☐ Yes Date: _____ ☐ Not Available

Do you have a **Durable Power of Attorney** for Health Care decision making? ☐ Yes ☐ No

Requested from Patient / Family ☐ Yes ☐ No ☐ N/A

Written information on advanced directives given to patient? ☐ Yes ☐ No

PART OF THE MEDICAL RECORD

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SENSORY / COGNITION

HISTORY

SENSORY / COGNITION ☐ No Impairment

Hearing: ☐ Impaired ☐ R ☐ L
☐ Deaf ☐ R ☐ L ☐ Aid

Vision: ☐ Impaired ☐ R ☐ L ☐ R ☐ L
☐ Blind ☐ R ☐ L
☐ Glasses ☐ Contacts ☐ Eye Prosthesis

Comment: _____

Are you having any difficulty reading? ☐ Yes ☐ No

Explain: _____

☐ Seizures ☐ Syncope ☐ Memory Loss ☐ Other _____

Sleep / Rest Problems: ☐ Yes ☐ No

If "Yes", what do you do at home to sleep? _____

ASSESSMENT

EYES:

☐ PERLA If unequal, specify: _____

☐ Redness ☐ Drainage ☐ Other: _____

☐ Speech: ☐ Clear ☐ Slurred ☐ Non Verbal

☐ Foreign Language: _____

What is patient's response to Questions 1 - 4?

1) Today's date? _____
2) Your birthday and age? _____
3) Name of hospital? _____
4) Where is the hospital located? _____

Level of consciousness: ☐ Alert ☐ Lethargic ☐ Unresponsive

Oriented: ☐ To Time ☐ To Place ☐ To Person
☐ Confused ☐ Easily Distracted ☐ Unable to Focus

BEHAVIOR: ☐ Cooperative ☐ Restless ☐ Agitated ☐ Depressed
☐ Angry ☐ Anxious ☐ Fearful ☐ Tearful ☐ Tremulous
☐ Inappropriate Behavior or Responses ☐ Guarded ☐ Combative
☐ Assaultive ☐ Threatening ☐ Resistant

PAIN

ACUTE PAIN: ☐ No Acute pain

Location: _____
Intensity (0-10): _____ Scale _____
Comfort Goal: _____
Quality (Patient's own words): _____
Onset: _____ Pattern _____
Aggrevating Factors: _____
Alleviating Factors: _____
Impact on Functional Ability: _____
Impact on Quality of Life: _____

PAIN MANAGEMENT HISTORY:

Helpful: _____
NOT Helpful: _____

CHRONIC PAIN: ☐ No Chronic pain

Location: _____
Intensity (0-10): _____ Scale _____
Comfort Goal: _____
Quality (Patient's own words): _____
Onset: _____ Pattern _____
Aggrevating Factors: _____
Alleviating Factors: _____
Impact on Functional Ability: _____
Impact on Quality of Life: _____

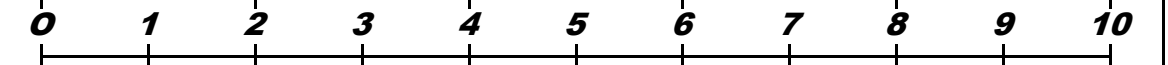
PAIN MANAGEMENT HISTORY:

Helpful: _____
NOT Helpful: _____

PAIN SCALES:

WONG-BAKER: *(Faces)*

0-10 VISUAL: *(Numerical)*



VERBAL:

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
2. Record FLACC Score using the 0-10 VISUAL (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

REPRODUCTIVE / SEXUALITY

LMP _____ ☐ Regular ☐ Irregular ☐ Postmenopausal ☐ Penile Discharge ☐ Vaginal Discharge ☐ Abnormal Bleeding

Pregnancy Hx: Gr _____ P _____ A _____

Type of Delivery: ☐ Full-Term ☐ Pre-term ☐ Vaginal ☐ C / S

STD's: _____

Sexual Function Issues: _____

Contraception: _____

Specify: _____

Lesions (Specify): _____

Do you practice breast self-exam? ☐ Yes ☐ No

Do you practice testicular self-exam? ☐ Yes ☐ No ☐ N/A

☐ No reproductive / sexual issues identified

PART OF THE MEDICAL RECORD

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CARDIOVASCULAR

HISTORY	ASSESSMENT
☐ No Impairment	Skin Condition ☐ Dry ☐ Diaphoretic
☐ Hypertension ☐ CHF	Color: ☐ Normal ☐ Pale ☐ Cyanotic ☐ Other (specify)
☐ Pacemaker Insert Date:	Apical Pulse: / min
☐ Angina / Chest Pain ☐ Previous M.I.	Radial Pulse: ☐ Regular ☐ Irregular
☐ Palpitations / Dysrhythmias	Pedal Pulse: ☐ Present ☐ R Absent ☐ L Absent
☐ Very Cold / Numb Extremities	Edema: ☐ None ☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg
☐ DVT / PE	Comments:
☐ CABG	Vascular Access (specify kind & location):
☐ Other (Specify)	

RESPIRATORY

☐ No Respiratory Problems	☐ Orthopnea ☐ Dyspnea ☐ Tachypnea ☐ SOB
☐ Asthma	☐ Cough
☐ Bronchitis	☐ Sputum Production Specify Color: Amt:
☐ Chronic Obstructive Pulmonary Disease	CHEST APPEARANC Symmetrical Retraction Deformities
☐ Sleep Apnea	Left Lung ☐ CLEAR ☐ Right Lung
☐ Pneumonia	Left Lung ☐ DIMINISHED ☐ Right Lung
☐ Home O2	Left Lung ☐ RALES ☐ Right Lung
☐ Other (specify)	Left Lung ☐ RHONCHI ☐ Right Lung
	Left Lung ☐ WHEEZES ☐ Right Lung
	☐ Oxygen ☐ Chest Tube ☐ Trach ☐ ET Tube ☐ Other

NUTRITION

Unplanned weight loss (10-15 lbs) in the last 6 months) ☐ Yes ☐ No	
Difficulty chewing or swallowing ☐ Yes ☐ No	Dentures ☐ None ☐ Upper ☐ Lower ☐ Partial
If yes, Liquids? ☐ Yes ☐ No Solids? ☐ Yes ☐ No	
☐ sore mouth ☐ dentures ☐ inability to feed self	☐ N/G Tube ☐ Small-bone Feeding Tube
Nausea, vomiting or diarrhea daily for 3 days pre-admission? ☐ Yes ☐ No	☐ PEG Tube ☐ Jejunostomy Tube ☐ Gastrostomy Tube
A "YES" answer to any item results in a dietary consult	

ELIMINATION

Bowel: ☐ Diarrhea ☐ Constipation ☐ Rectal Bleeding ☐ Incontinence	☐ Abdomen Soft ☐ Abdomen Tender ☐ Abdomen Distended
Last BM Usual Pattern	Bowel Sounds: ☐ Present ☐ Absent
Bladder: ☐ Urgency ☐ Nocturia ☐ Incontinence ☐ Burning	
☐ Retention ☐ Frequency ☐ Anuria ☐ Dialysis	☐ Foley Catheter ☐ Urostomy * ☐ Colostomy / Ileostomy *
☐ No elimination problems noted	☐ External Catheter * If YES, Request ET Consult

EDUCATION

- ☐ Needs full knowledge about:
- ☐ Needs refresher about:

Patient's preference for learning information: ☐ TV / Video ☐ Reading ☐ Teaching 1:1 ☐ Groups ☐ Tapes

Interdisciplinary Patient Educational Assessment Form Initiated: ☐ Yes ☐ No

DISCHARGE

DISCHARGE ASSESSMENT (ANTICIPATED ASSISTANCE NEEDED) ☐ None Anticipated at Present

Place of Residence: ☐ Home ☐ Nursing Home ☐ Res. Facility ☐ Senior Housing ☐ Shelter ☐ Homeless

Source of Medical Care: ☐ None ☐ Private MD ☐ Clinic ☐ Other:

Health Services at Home (Specify) ☐ None ☐ Nurse ☐ Homemaker ☐ Social Worker ☐ PT ☐ OT ☐ Speech ☐ Hospice

☐ Other: / ☐ Home Health Aide

Do you feel you will need additional help with care at home? ☐ No ☐ Yes (describe):

REFERRALS

BASED ON ADMISSION ASSESSMENT, PLEASE CHECK NEEDED SERVICES: ☐ None anticipated at present

☐ Case Management Dept ☐ Food & Nutrition Services ☐ Wound, Ostomy & Continence Nurse (ET)

☐ Diabetes Nurse Educator ☐ Rehabilitative Services ☐ Other:

Reason for Referrals:

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ACTIVITY

MUSCULOSKELETAL GAIT: ☐ Normal ☐ Abnormal

☐ No musculosketel problems
☐ Limited ROM: ☐ Rt. Arm ☐ Lt. Arm ☐ Rt. Leg ☐ Lt. Leg
☐ Amputation ☐ Rt. Arm ☐ Lt. Arm ☐ Rt. Leg ☐ Lt. Leg
DEVICES: ☐ Cane ☐ Quad Cane ☐ Crutches ☐ Walker
☐ W/C ☐ Braces ☐ Prosthesis ☐ Other

FALL RISK ASSESSMENT CRITERIA

INSTRUCTIONS: For any "YES" response, initiate the Fall Risk Assessment Protocol and include safety problem on Patient Care Portfolio.

A. History of falls, use of restraints.	☐ Yes	☐ No
B. Ambulation / gait problems, use of adaptive devices (i.e., canes, walkers, prosthesis)	☐ Yes	☐ No
C. Weakness / paresis	☐ Yes	☐ No
D. Confusion, disorientation, impulsiveness, agitation, combativeness, seizures	☐ Yes	☐ No
E. Incontinence / urgency, diarrhea, frequent toileting	☐ Yes	☐ No
F. Post-op within 48 hours, sedatives, narcotic analgesics	☐ Yes	☐ No

ADL'S

PRE ADMISSION:

AMBULATION:	☐ Self	☐ Assist	☐ Complete
DRESSING:	☐ Self	☐ Assist	☐ Complete
MEAL PREPERATION:	☐ Self	☐ Assist	☐ Complete
FEEDING:	☐ Self	☐ Assist	☐ Complete
BATHING:	☐ Self	☐ Assist	☐ Complete
TOILETING:	☐ Self	☐ Assist	☐ Complete

REHAB TRIGGERS: A "YES" answer to above items triggers request to physician for consult for appropriate rehab discipline

PT - Recent and significant decline in functional mobility (ambulation, transfers, bed mobility): ☐ Yes ☐ No
OT - Recent and significant change in ADL's: ☐ Yes ☐ No
Speech - Consistently coughs when eating and/or drinking: ☐ Yes ☐ No

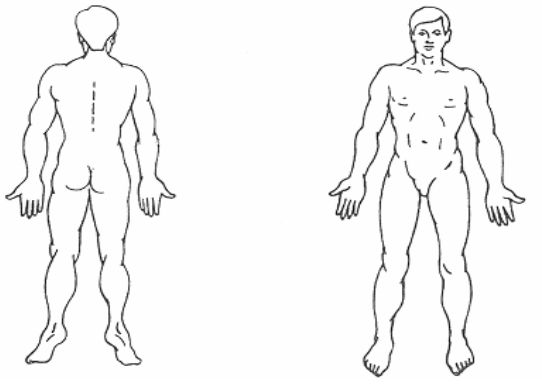
SKIN INTEGRITY

PHYSICAL MARKINGS: Any Pressure Ulcer should be staged, measured & described in Admitting Nurse's Notes.

☐ **NONE**
☐ ABRASIONS
☐ SCARS
☐ CONTUSIONS
☐ RASH
☐ PRESSURE ULCERS *
☐ HEALED PRESSURE ULCER * - or - FLAP *
☐ OTHER

* OBTAIN Dietary Consult + Stamp ORDER SHEET w/ Serum Albumin Request

Braden Score for Pressure Ulcer Risk



BRADEN SCORE FOR PREDICTING PRESSURE ULCER RISK

INSTRUCTIONS: Circle the number in each column that best describes the criteria.

SENSORY PERCEPTION	MOISTURE	ACTIVITY	MOBILITY	NUTRITION	FRICTION & SHEAR
1 COMPLETELY LIMITED	1 CONSTANTLY MOIST	1 BEDREST	1 COMPLETELY IMMOBILE	1 VERY POOR	1 PROBLEM
2 VERY LIMITED	2 VERY MOIST	2 CHAIRFAST	2 VERY LIMITED	2 PROBABLY INADEQUATE	2 POTENTIAL PROBLEM
3 SLIGHTLY LIMITED	3 OCCASIONALLY MOIST	3 WALKS OCCASIONALLY	3 SLIGHTLY LIMITED	3 ADEQUATE	3 NO APPARENT PROBLEM
4 NO IMPAIRMENT	4 RARELY MOIST	4 WALKS	4 NO LIMITATIONS	4 EXCELLENT	
SCORE	**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**

A total score of < 17 = high risk pressure ulcer patient. Implement Pressure Ulcer Prevention Protocol. **TOTAL SCORE:** _____

NURSING NOTES

PRINT NAME / TITLE	SIGN NAME	DATE	Military TIME
PRINT NAME / TITLE	**SIGN NAME**	**DATE**	Military **TIME**

PART OF THE MEDICAL RECORD