

NURSES' ADMISSION RECORD

(To be completed by the nurse admitting the patient)

Family Name	First Name	Middle Name	Room No.	Bed No.	Admission No.
Attending Physician			Date		Time

Admitting Diagnosis _____

Take and record Vital Signs

Date _____ T _____ P _____ R _____ B.P. _____ / _____ Pain _____ Weight _____ Height _____

Orientation of Patient to Facility

Oriented to functions of call light <input type="checkbox"/>	Oriented to facility visiting hours <input type="checkbox"/>
Oriented to procedures of meal times <input type="checkbox"/>	Oriented to location of room <input type="checkbox"/>
Oriented to smoking regulations <input type="checkbox"/>	Resident wishes to self-medicate
Oriented to activity program <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

(If "Yes", refer to ID Team Assessment)

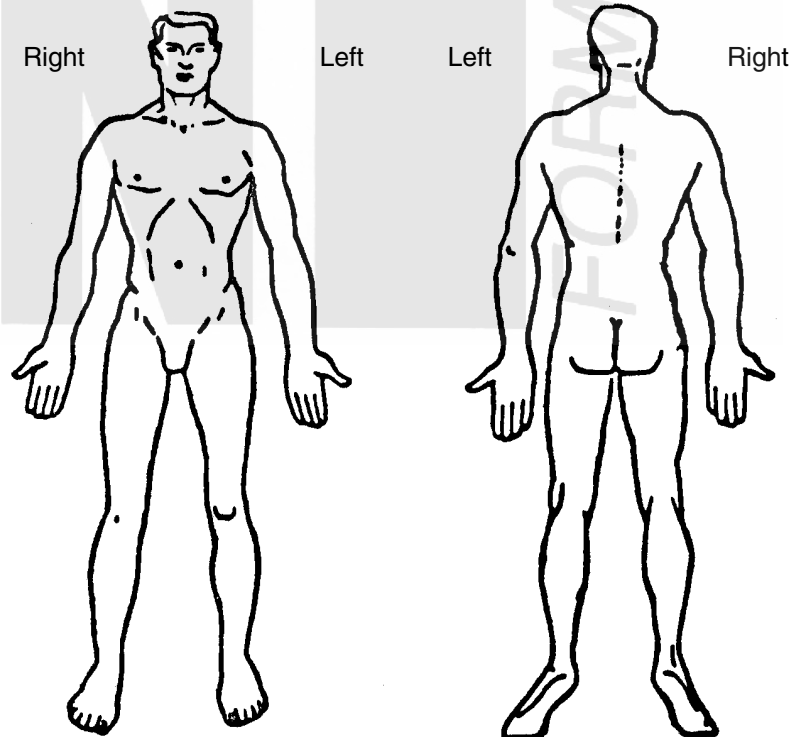
Patient wears: Dentures Glasses Hearing Aid Other _____
SPECIFY

Has prosthesis of: Breast Leg Arm Other _____
SPECIFY

General physical appearance _____

General condition of skin _____

Indicate on diagram below all body marks such as old or recent scars, bruises or discolorations (regardless of how slight), lacerations, decubitus ulcers and other ulcerations or questionable markings considered other than normal;



Signed _____

Licensed Nurse