NURSING HISTORY AND ADMISSION ASSESSMENT

DO NOT REMOVE FROM CHART

PART I ADMISSION RECORD (Complete at time of admission)

Date _____ Time _____ Ht. _____ Wt. _____ Sex _____ Age _____

T _____ P (Rate / Quality) _____ R (Rate / Quality _____ BP _____

DIAGNOSIS: _____

_____

_____

ADM. BY: Ambulance Car ADM. FROM: Home Hospital SNF B & C

ACCOMPANIED BY: _____ VIA: Guerney W.C. Ambulatory

PROSTHESES: Breast Leg Arm Eye Other _____

SPECIAL AID/EQUIPMENT NEEDED: ☐ Wheelchair ☐ Walker ☐ Cane

☐ Brace ☐ Restraint ☐ Abduction Pillow ☐ Traction ☐ Others:

RESPIRATORY (Circle the appropriate words)

Respirations: Regular Bradypnea Labored Tachypnea Orthopnea Dyspnea Shallow Deep Kussmaul Cheyne-Stokes

Breath Sounds: Clear ____ Location of: Wheeze ____ Rub ____ Rales/Crackles ____ Rhonchi

Audible Bilaterally ____ Absent ____ Diminished ____

CARDIOVASCULAR (Indicate the appropriate numbers)

Ø - Absent

1. Weak 4. Strong Radial R ____ L ____
2. Thready 5. Regular Pedal R ____ L ____
3. Bounding 6. Irregular

Abdomen: Soft Distended Flat Rigid Tender

Bowel Sounds: Active Hyperactive Hypoactive Absent

TELEMETRY (Circle the apropriate word) NA

Rhythm: RSR SBRADY STACH A FIB A FLUTTER

SVT PVC's PAC's PJC's Other: _____

Pacemaker _____

ORIENTATION: (If unable to do, state reason)

_____ Call light
_____ Side Rails
_____ Bath Room
_____ Closet / Personal Belongings
_____ Room Location
_____ Roommate / Residents
_____ Public Rooms
_____ Meal Times
_____ Food Preference Interview
_____ Menu Location
_____ Dining Room
_____ Activities Program / Calendar
_____ Smoking Rules
_____ Visiting Hours
_____ Laundry by Center
_____ Laundry by Family
_____ Pay Phone
_____ Beauty / Barber (Shops)
_____ Exits / Patios
_____ Therapy Rooms
_____ Staff Introduction

ORIENTATION GIVEN TO: Patient ☐ Other (State to whom given) _____

ORIENTATION GIVEN BY (Signature / Title) _____

LICENSED NURSE ADMITTING NOTES: _____

_____

_____

_____

_____

_____

_____

_____

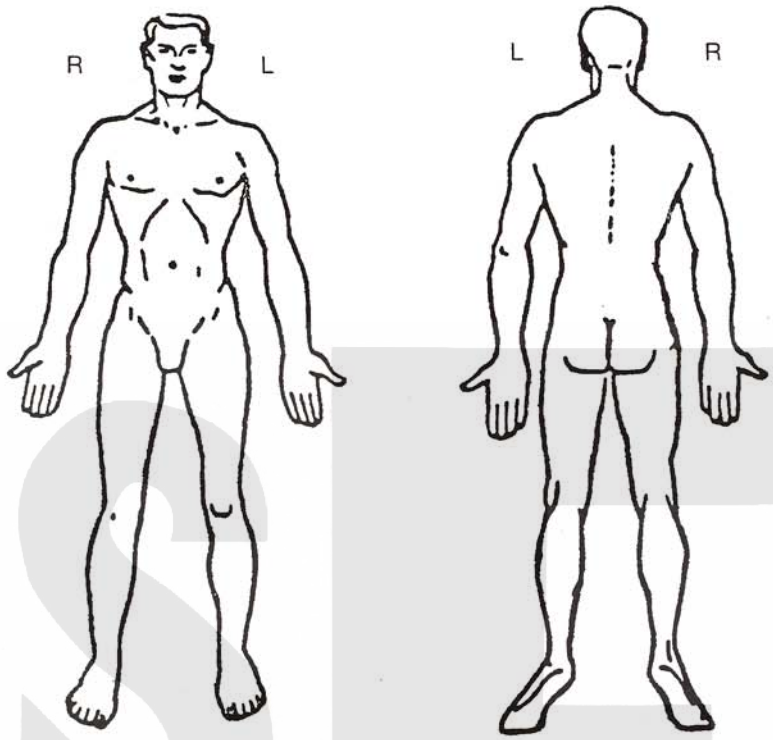
_____

_____ Licensed Nurse Signature _____

Name _____ MR # _____ Dr. _____

PART II ADMISSION BODY CHECK (Complete at the time of admission)

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, rashes or questionable markings considered other than normal; amputated parts, dialysis shunts. Presence of Dressing (Type).



CONDITION OF: Hair, (Scalp) _____

Nails (Fingers, Toes) _____

Mouth and Teeth _____

Skin _____

Foot Care (heels, toes, sole) _____

PRESENCE OF VERMIN ☐ Yes ☐ No PRESENCE OF FACIAL HAIR ☐ Yes ☐ No

PRESENCE OF CONTRACTURES / DEFORMITIES (area) _____

PRESENCE OF EDEMA (area) _____

PRESSURE ULCER RISK ASSESSMENT - Check the applicable number and total number of points of risk factors.

GENERAL PHYSICAL CONDITION	COGNITIVE	ACTIVITY LEVEL	MOBILITY	INCONTINENCE	WEIGHT	SCORE
4. Good	4. Memory OK	4. Ambulatory	4. Full	4. Continent	4. Above IBW	
3. Fair	3. Needs reminders to do things	3. Ambulatory with help	3. Slightly	3. Usually Incontinent	3. Within IBW	
2. Fair/Good	2. Can't find locations	2. Chair-bound or bed	2. Very limited	2. Frequently Incontinent	2. IBW Borderline	
1. Poor	1. Comatose, no awareness	1. Bedfast	1. Immobile	1. Double Incontinent	1. Below IBW	
					TOTAL	

A. 15 & ABOVE POINTS - Little Risk B. 10-13 POINTS - Moderate C. BELOW 10 POINTS - High Risk

(HIGH RISK MUST BE ADDRESSED IN THE CARE PLAN) SUMMARY SCORE: _____

Licensed Nurse Signature _____

PART III HISTORY / ASSESSMENT. (Complete by Licensed Nurse)

Date of Assessment _____ Nurse Signature _____

Patient / Resident requires services of a registered nurse ☐ Yes ☐ No

ALLERGIES

__ Food
__ Drugs
__ Other

TB SCREENING

__ Type
__ Date
__ Result

ADLS

Assign Proper # to ADL Status (Refer to MDS for explanation of Categories)

0 INDEPENDENT
1 SUPERVISION
2 LIMITED ASSISTANCE
3 EXTENSIVE ASSISTANCE
4 TOTAL DEPENDENCE

_____ Walking
_____ Transferring
_____ Wheeling
_____ Bathing
_____ Dressing
_____ Grooming
_____ Toileting
_____ Moving / Turning
_____ Bedfast

HEARING

__ No apparent problems
__ Mild problem L R Both
__ Deaf L R Both
__ Wears hearing aid
__ Deafness corrected by aid
__ Deafness not corrected

VISION

__ No apparent problems
__ Correctable w glasses
__ Severe impairment
__ Legally Blind
__ Totally Blind

SLEEP

__ Restless - no med
__ Restless - needs med
__ Sleeps well - no med
__ Sleeps well - needs med
Usual bedtime _____
__ Needs nap/Time _____

EATING / FEEDING

__ Feeds self
__ Feeds self c assistance
__ Needs partial help
__ Needs to be fed
__ N-G tube
__ Gastrostomy
__ Parenteral
__ Supplemental feedings
__ Swallowing problem
__ Chewing Problem
__ Candidate for Feeding program

COMMUNICATION

__ Languages spoken
__ Writes
__ Reads
__ No speech handicaps
__ Aphasia complete
__ Aphasia partial
__ Cannot speak but seems to understand
__ Makes needs known signs gestures
__ Unable to make needs known

MENTAL / BEHAVIORAL

*Person-Place-Time
__ Receiving Psych Care
__ Alert
__ Semi-Coma
__ Coma
*Oriented to P P T
*Disoriented to P P T
__ Forgetful
__ Wanders
__ Noisy
__ Agitated
__ Hyperactive
__ Cooperative
__ Uncooperative
__ Combative
__ Physically Aggressive
__ Verbally Abusive
__ Passive
__ Stays to Self
__ Doesn't talk, eat
__ Sad, Afraid
__ Can follow instructions

MEDICATIONS

__ Antibiotics
__ Anticoagulants
__ Cardiac drugs
__ Diuretics
__ Chemotherapy
__ Insulin
__ Psychotropics
__ Hypnotics
__ Narcotics
__ Oral Hypoglycemic

SPECIAL NEEDS / PROBLEM

__ Amputee - location
__ Brace / Cast
__ Seizures Tremors
__ Paralysis - area
__ Joint Motion / pain / swelling
__ Oxygen Therapy
__ Ventilator
__ IPPB
__ Trach Care
__ Suctioning
__ Injections
__ IV Therapy
__ Fluid Retention
__ Isolation
__ Contractures - area
__ Renal Dialysis
__ Colostomy
__ Ileostomy
__ Foley Catheter
__ Other

DIABETIC CARE

__ Unable to manage diabetic condition
__ Regulated by diet only
__ Regulated with meds
__ Uncontrolled
__ Blood Testing

WOUND CARE

__ Dry dressings
__ Medicated dressings
__ Surgical Incision
__ Sutures inplace
__ Decubitus

REHABILITATION

__ P.T.
__ O.T.
__ Speech
__ RNA

(Circle Appropriate Level)

PAIN RATING SCALE (Severity)

0 = NO PAIN
1 = MILD PAIN
2 = MODERATE PAIN
3 = DISTRESSING PAIN (MOANING)
4 = SEVERE PAIN (CRYING OUT)
5 = EXCRUCIATING

LEVEL OF CONSCIOUSNESS

0 = ALERT / WIDE AWAKE
1 = DROWSY, BUT AROUSABLE
2 = INCREASED CONFUSION / DOSING INTERMITTENTLY
3 = SLEEPING
4 = STUPOR / RESPONSE TO PAINFUL STIMULI ONLY
5 = COMA

1. Origin/Location of Pain _____
2. (alleviation)/current Tx _____
3. effectiveness _____

RISK FACTOR ASSESSMENT

A MENTAL STATUS		B. ELIMINATION:		C. PSYCHOTROPICS / ANALGESIA	
Oriented at all times or comatose	0	Independent and continent	0	Routine	3
Confused at all times	2	Foley Catheter	1	PRN 3 – 5 Q day	2
Intermittent confusion	3	Elimination with assistance	2	PRN less than 3 Q day	1
		Independent and incontinent	3	**F. MOBILITY STATUS:**	
D. VISUAL IMPAIRMENT	2	**E. HISTORY OF FALL**		Bedbound	0
		No History of Falling	0	Wheelchair bound	1
		Has Fallen 1 or 2 items before	2	Ambulates independently	1
		History of multiple falls	3	Ambulates with assist	2
				Poor Trunk balance	2
				Poor Trunk balance	2
				Slides	2
				Sits independently	1

SCORES: LESS THAN 9 = LEVEL I | **10 – 13 = LEVEL II** | **14+ = LEVEL III**

SIDERAIL USAGE:

☐ Resident Requested *☐ Safety ☐ Positioning *☐ Falling *☐ Climbing out of bed

* If checked must have consent & assessment for least restrictive mode

PART IV BOWEL / BLADDER ASSESSMENT (Initiate upon admission - Complete within 14 days)

BOWEL (Circle One) CONTINENT INCONTINENT OCCASIONAL ALWAYS

Totally independent? _____ Yes No Ostomy? Yes No Type _____ Mental Status _____

Past Pattern: _____ Frequency _____ Time of Day _____ Consistency _____ Impactions? Yes No

Laxative / Suppository? Yes No Type _____ Enemas? Yes No Type _____

Foods Help? Yes No Type _____ Fluids Help? Yes No Type _____

_____

Mobility Problems? Yes No Describe _____

Resident's feelings / suggestions: _____

BLADDER (Circle One) CONTINENT INCONTINENT _____

Totally independent? Yes No Mental Status _____

Hx: bladder problems? Yes No Describe _____

Present pattern: Incontinence frequency: Occasional Always Stress Night Only

Complaints: Urgency Burning Dribbling Other _____

Catheter in place? Yes No Placed recently? Yes No Date if known _____

Reason for catheter (incontinence is not acceptable) _____

Recent Abnormal lab values: (related to GU) _____

ABLE TO PARTICIPATE IN RETRAINING? Yes No (reason if No) _____

_____

MANAGEMENT PLAN: _____

_____

_____ _____

Date Signature