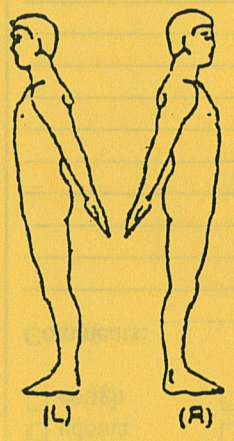
# RESIDENT ADMISSION AND ASSESSMENT FORM

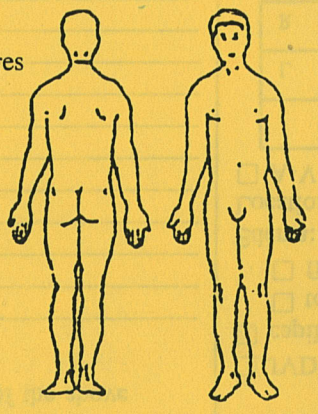
RESIDENT'S PERCEPTION AS TO WHY THEY ARE BEING ADMITTED: _____

_____

## SKIN ASSESSMENT




- ☐ skin integrity intact: ☐ yes ☐ no
- ☐ rash
- ☐ reddened area
- ☐ pressure sore
- ☐ scars
- ☐ Hx of pressure sores
- ☐ bruise
- ☐ skin tear
- ☐ abrasion
- ☐ laceration
- ☐ lesion
- ☐ burn
- ☐ suture
- ☐ staples
- ☐ cast
- ☐ steri-strips
- ☐ drainage
- ☐ edema
- ☐ incision
- ☐ other



Comments: (assess scalp, hair, skin, masses, tumors, etc.) Describe findings of any identified skin problems and indicate area size depth (cms), color and drainage.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES: _____

_____

MOISTURE: ☐ dry/flaking ☐ oily ☐ clammy

COLOR: ☐ pink ☐ pale ☐ flushed
☐ jaundice ☐ ashen ☐ cyanotic ☐ other

TURGOR: ☐ normal ☐ fair ☐ poor

_____

TEMPERATURE: ☐ cool ☐ warm

TEXTURE: ☐ calloused ☐ coarse ☐ thin/translucent ☐ smooth

_____

| ADL ASSESSMENT | INDEPENDENT | ASSIST | COMMENTS |
|---|---|---|---|
| Bathing | | | |
| Grooming | | | |
| Toileting | | | |
| Eating | | | |

## SENSORY ASSESSMENT

HEARING:
☐ adequate ☐ impaired ☐ deaf Cerumen (external): ☐ Yes ☐ No☐
☐ hearing aides: L ☐ R ☐

VISION:
☐ adequate ☐ impaired ☐ prosthesis: ☐ L ☐ R ☐ glasses
☐ lenses ☐ implant ☐ other_____
☐ contacts

| LAST NAME | FIRST NAME | INIT. | ATTENDING PHYSICIAN | ROOM NO. | RESIDENT NUMBER |
|---|---|---|---|---|---|
| | | | | | |

## BEHAVIOR/COGNITIVE/SAFETY ASSESSMENT

☐ alert ☐ fearful ☐ anxious ☐ verbally abusive
☐ confused ☐ forgetful ☐ cooperative ☐ threatening
☐ withdrawn ☐ wanders ☐ combative ☐ disruptive
☐ other _____ ☐ none of the above

COMMENTS: (describe specific behavior)
_____
_____
_____
_____
_____

## GASTROINTESTINAL SYSTEMS HISTORY

**Appetite:** ☐ good ☐ fair ☐ poor

☐ nausea ☐ vomiting ☐ heartburn
☐ constipation ☐ diarrhea ☐ rectal bleeding
☐ incontinence (bowel) ☐ ostomy
☐ recent weight change ☐ none of the above
☐ laxatives ☐ other _____

Comments: _____
_____

☐ unable to obtain history

## NUTRITION BASELINE ASSESSMENT

☐ oral ☐ NG ☐ GT ☐ JT ☐ TPN ☐ IV ☐ other _____
Admission Weight: _____ Height: _____
Bowel Sounds: Positive all 4 quad. ☐
Other: _____
Abdomen: ☐ hard ☐ soft ☐ distended ☐ flat
☐ pain/tenderness ☐ ostomy
☐ other _____
_____
_____

## GENITOURINARY SYSTEMS HISTORY

☐ burning ☐ frequency ☐ urgency
☐ Hx of UTI(s) ☐ dysuria ☐ dribbles
☐ nocturia ☐ incontinent (urine) ☐ continent
☐ other _____ ☐ none of the above

Comments: _____
_____
_____

☐ unable to obtain history

## GENITOURINARY BASELINE ASSESSMENT

☐ bladder distention ☐ indwelling catheter size_____
Urine: describe color, odor, clarity (if observed) reason for indwelling catheter _____
☐ continent ☐ incontinent
☐ ostomy ☐ normal ☐ other _____
External Genitalia:
☐ normal ☐ other _____
_____

## CARDIOVASCULAR SYSTEMS HISTORY

☐ chest pain ☐ palpitations ☐ hypertension
☐ edema ☐ pacemaker ☐ arrhythmia
☐ cough ☐ dyspnea ☐ none of the above

Comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ unable to obtain history

## CARDIOVASCULAR BASELINE ASSESSMENT

T ____ P (apical)____ R (radial)____ R ____ B/P: L _____
☐ regular R _____
☐ irregular
☐ JVD
☐ capillary refill brisk ☐ other _____
☐ toes
☐ fingers
Edema: ☐ none ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
Location: _____
☐ A-V shunt ☐ bruit ☐ thrill

| | Radial | Dorsal/Pedal | Popliteal |
|---|---|---|---|
| L | | | |
| R | | | |

✓ box if present

Comments: _____
_____

Nurse's Signature: _____ Time: _____ Date: _____

## PAIN SYSTEMS HISTORY

Any pain experienced lately ☐ no ☐ yes
Location: _____

Effects of pain: (function, appetite, irritability, accompanying symptoms, etc.) _____

Pain Meds: _____ _____ _____

Comments: _____

☐ unable to obtain history

## PAIN BASELINE ASSESSMENT

Any pain experienced currently? ☐ no ☐ yes
Onset: _____
Provocation/palliation: _____
Quality: _____
Region/radiation: _____
Severity: 1 (no pain) 2 (mild) 3 (discomforting) 4 (severe) 5 (excruciating)
Time (duration) _____
☐ Consistent ☐ inconsistent
Nonverbal: ☐ grimaces ☐ restlessness ☐ crying ☐ moaning ☐ guarding ☐ other _____
Comments: _____

## DENTAL SYSTEMS HISTORY

☐ own teeth ☐ edentulous
☐ partial: ☐ dentures:
☐ upper ☐ upper
☐ lower ☐ lower
Medical conditions/medications/treatments that may affect oral cavity: _____

Comments: _____

☐ unable to obtain history

## DENTAL BASELINE ASSESSMENT

**Oral Cavity:**
☐ pink ☐ moist ☐ lesions under tongue
☐ tenderness ☐ discharge ☐ other _____
☐ halitosis ☐ debris
☐ broken, loose or carious teeth
☐ broken, loose fitting dentures/partial
**Gums:**
☐ normal ☐ inflamed ☐ bleeding ☐ other _____
Comments: _____

## FOOT SYSTEMS HISTORY

☐ Hx of pressure sores: (location) _____
☐ numbness ☐ tingling
☐ Hx of surgery _____
☐ Hx of venous/arterial ulcers _____
☐ special footwear needs: _____

Comments: _____

☐ unable to obtain history

## FOOT BASELINE ASSESSMENT

☐ corns ☐ capillary refill brisk ☐ other _____
☐ callus ☐ bunions ☐ hammer toes
☐ none of the above
skin integrity intact:
malleolus L ☐ R ☐ temp. normal ☐
heel L ☐ R ☐ color normal ☐
spongy L ☐ R ☐

Nails: ☐ mycotic ☐ hypertropic nails ☐ normal ☐ ingrown

☐ Oriented to facility, routines, layout, rights and responsibilities.

Other: (diabetes, thyroid, etc.) if unable to assess any system explain reason: _____

Notes: _____

Nurse's Signature: _____ Time: _____ Date: _____

| LAST NAME FIRST NAME INIT. | ATTENDING PHYSICIAN | ROOM NO. | RESIDENT NUMBER |
|---|---|---|---|
| | | | |

## RESPIRATORY SYSTEMS HISTORY

☐ irregular ☐ labored ☐ shallow
☐ cough ☐ nonproductive ☐ productive
☐ secretions: color _____ consistency _____ amt _____
☐ history of smoking ☐ accessory muscles
☐ trach size _____ ☐ none of the above
☐ use of suctioning
Comments: (lung disease problems) _____
_____
_____
_____
_____
☐ unable to obtain history

## RESPIRATORY BASELINE ASSESSMENT

Breath Sounds: ☐ clear ☐ rhonchi ☐ wheezes ☐ crackles
☐ dyspnea ☐ orthopnea

Comments: _____
_____

☐ $O_2$ ____ L/Min ☐ N/C ☐ mask

Cough: ☐ none ☐ weak ☐ strong ☐ congested
Secretions:
color _____ consistency _____ amount _____
Pulse Ox: _____ (if indicated)

## MUSCULOSKELETAL SYSTEMS HISTORY

☐ back pain ☐ pain in joints/muscles ☐ amputations
☐ stiffness ☐ fractures ☐ other _____
☐ none of the above
Comments: (orthopedic problems, specify) _____
_____
_____
_____
☐ unable to obtain history

## MUSCULOSKELETAL BASELINE ASSESSMENT

☐ none ☐ weakness
☐ paralysis location: _____
☐ contractures location: _____
☐ amputations location: _____
☐ kyphosis
Describe deformities, assistive/supportive/prosthetic devices, mobility, etc. _____
_____

## NEURO SYSTEMS HISTORY

☐ headaches ☐ dizziness ☐ seizures ☐ CVA
☐ sensation loss ☐ weakness of limbs
☐ quadriplegia ☐ paraplegia ☐ aphasia
☐ dementia (other than Alzheimers)
☐ other _____ ☐ none of the above
Comments: _____
_____
_____
_____
_____
_____
☐ unable to obtain history

## NEURO BASELINE ASSESSMENT

| | | |
|---|---|---|
| alert: | | ☐ yes ☐ no |
| oriented to: | person | ☐ yes ☐ no |
| | place | ☐ yes ☐ no |
| | time | ☐ yes ☐ no |
| | situation | ☐ yes ☐ no |
| follows simple commands: | | ☐ yes ☐ no |
| moves all extremities: | | ☐ yes ☐ no |
| perrla: | | ☐ yes ☐ no |
| affect appropriate: | | ☐ yes ☐ no |
| bilateral hand grips: | | ☐ equal ☐ other |
| tremors: | | ☐ yes ☐ no |

Comments: _____
_____

## SLEEP PATTERNS SYSTEMS HISTORY

☐ insomnia normal bed time: _____
☐ naps usual wakeup time: _____
usual nap time: _____ ☐ am ☐ pm ☐ sleep apnea
routine sleep meds: ☐ no ☐ yes _____
Comments: _____
_____
_____
☐ unable to obtain history

## SLEEP PATTERNS BASELINE ASSESSMENT

Comments: _____
_____
_____
_____
_____
_____
_____