Your Hospital's Logo Here

PATIENT IDENTIFICATION

Admission Data Base Form

Psychiatric Unit

Section I: General Information

Admitted from:

Date _____/_____/_____ **Time** _____

☐ **Emergency Room** ☐ **Medical Unit** ☐ **Admitting Department** ☐ **Other** _____

Age	Temperature	Pulse	Respiration	Blood Pressure	BAL	Height	Weight

Accompanied By

Informant

Section II: Psychosocial Assessment

Part A: Socioeconomic Status

Ethnic/Cultural Background

Religious Affiliation

Do you have any spiritual or cultural practices that may affect your medical care or hospitalization? If yes, describe. ☐ Yes ☐ No

Primary Language

Education Level

Occupation or Skills

Current Employment Status

Income Source Monthly Income

Does Income Meet Needs?

Living Situation

☐ Shelter

☐ Group Home/CRF

☐ Nursing Home

☐ Home, Apartment or Room

☐ Other _____

Living with Whom:

Can you return to your present housing?

Part B: Support Network

Name of Spouse/Significant Other	Last Seen	Age	Sex	Name of Other Family Member	Last Seen	Age	Sex
Name of Child	Last Seen	Age	Sex	Name of Other Family Member	Last Seen	Age	Sex
Name of Child	Last Seen	Age	Sex	Name of Other Family Member	Last Seen	Age	Sex
Name of Child	Last Seen	Age	Sex	Name of Other Family Member	Last Seen	Age	Sex

Name of Counselor/Therapist	Telephone Number
Name of Case Manager/Agency	Telephone Number
Name of Case Physician/Psychiatrist	Telephone Number

PART OF THE MEDICAL RECORD

Section II: Psychosocial Assessment (continued)

Part B: Support Network (continued)

Which of these people can be a source of support after discharge?

Are there any other people (not listed above) who can be a support after you leave the hospital?

Part C: Developmental History

Place of Birth:

Describe family makeup during childhood.

Describe most significant event as a child.

Describe most significant event as a teenager.

Describe most significant event as an adult so far.

Describe any emotional, health, and addiction problems in your family.

Were you in the Military? ☐ No ☐ Yes What Branch? _____ How Long? _____

Part D: Legal Status

Who makes legal decisions for you? ☐ Self ☐ Other _____ Telephone Number _____

Name of Conservator or Guardian:	Telephone Number

Describe any current legal problems and identify any pending court dates.

Name of Probation/Parole/Pre-Trial Officer and/or Attorney (if applicable):	Telephone Number

Have you ever been arrested (including DWI) and/or incarcerated?

How are your legal problems related to your substance abuse?

How are your legal problems related to your not taking your prescribed medications?

Signature and Credentials of Staff Member Completing Section II:	Date + Time of Completion of Section II:

Social Worker Review: ☐ Need Further Assessment (see progress notes) ☐ Does Not Need Further Assessment

Signature and Credentials of Social Worker Reviewing Section II:	Date + Time of Section II Review:

Section III: Nursing Assessment

Part A: Physical Status

If patient has had previous hospitalization for reasons other than mental health/substance abuse, explain where, when and for what reason.

Current Medications	Purpose	Dose / Schedule	Last Dose	Current Medications	Purpose	Dose / Schedule	Last Dose

PART OF THE MEDICAL RECORD

Part A: Physical Status (continued)

Current Medications	Purpose	Dose / Schedule	Last Dose	Current Medications	Purpose	Dose / Schedule	Last Dose

Disposition of medication: ☐ N/A ☐ Home ☐ Given to Family / Case Mgr ☐ Valuables Envelope

Allergies	Yes	No	Describe Substance and/or Reaction
Medication			
Food			
Environmental Substances			
Latex			

Drug and Alcohol Use

	Type	Date Last Used	Years/Months Used	Daily Usage Amount
☐ Alcohol				
☐ Amphetamine				
☐ Barbiturates				
☐ Cannabis				
☐ Cocaine				
☐ Hallucinogens				
☐ Inhalants				
☐ Opiates				
☐ PCP				
☐ Other Drugs				

Alcoholics Anonymous/Narcotics Anonymous or other 12-step group attendance:

If patient has a history of substance abuse, check each of the following that the patient has experienced.

☐ Blackouts ☐ Seizures ☐ Tremors ☐ Aches

☐ Hallucinations ☐ Gastrointestinal Distress ☐ Chills ☐ Diaphoresis

If patient has had previous treatment for substance abuse, explain where, when, and the results of treatment.

Cardiovascular	☐ No Problems		
☐ Chest Pain	☐ Palpitations	☐ Edema	☐ Activity Intolerance
☐ MI	☐ Hypertension	☐ Heart Surgery	☐ Other _____
Respiratory	☐ No Problems	☐ Emphysema/COPD	☐ Sleep Apnea
☐ Emphysema/COPD	☐ Asthma	☐ Cough	☐ Shortness of Breath
Smoker ☐ Yes ☐ No	If Smoker, how many PACKS / DAY?	For how many YEARS?	

Smoking Cessation information given? ☐ Yes ☐ No Offered but declined? ☐ Yes ☐ No

PART OF THE MEDICAL RECORD

Section III: Nursing Assessment (continued)

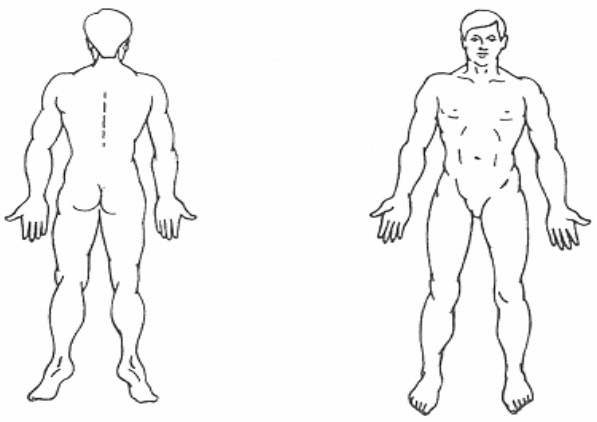
Part A: Physical Status (continued)

Nutrition	
☐ History of Diabetes	If yes, describe history (fingersticks?, insulin?):
Describe usual diet:	
Describe most recent meal:	
☐ Change in usual eating habits	If yes, describe change:
☐ ****Unplanned weight change** **(more than 10 lbs in last 6 months)**	If yes, describe change:
☐ Unusual eating habits (past or present) (e.g., bingeing, cravings, refusal to eat, etc.)	If yes, describe unusual eating habits:
☐ Dentures	If yes, describe change:
☐ ****Problems affecting chewing or swallowing**	If yes, describe problem:
☐ ****Nausea, vomiting or diarrhea** **(within 3 days of admission)**	If yes, describe details:

**** = INITIATE DIETARY CONSULT**

Gastro-Intestinal	☐ No Problems		
☐ Nausea	☐ Vomiting	☐ Hematemesis	☐ Pain
☐ Laxative Use	☐ Constipation	☐ Hemorrhoids	☐ Diarrhea
☐ Rectal Bleeding	Last BM _____	Other _____	
Urinary	☐ No Problems		
☐ Dysuria	☐ Frequency	☐ Nocturia	☐ ***Incontinence**
☐ Dialysis	☐ Other Problems _____		
Sensory/Neurological	☐ No Problems		
☐ ***Vision Problem**	☐ ***Hearing Problem**	☐ ***Current Dizziness**	☐ Head Trauma
☐ Glasses Worn	☐ Hearing Aid Worn	☐ Skin Lesions	☐ ***Seizure History** **(If seizure within last 72 hours)**
☐ Contact Lenses Worn	☐ ***Consciousness Level Changes**	☐ Other Problems _____	
☐ Other Problems _____			

Skin Integrity	(If box checked, describe)
NONE ☐	
Abrasions ☐	
Scars ☐	
Contusions ☐	
Pressure Areas ☐	
Rash ☐	
Decubitis ☐	
Lesions ☐	
Other ☐	



PART OF THE MEDICAL RECORD

Your Hospital's Logo Here

PATIENT IDENTIFICATION

Psychiatric Unit

Section III: Nursing Assessment (continued)

Part A: Physical Status (continued)

Rest and Sleep

Describe usual sleep pattern:

☐ Recent Sleep Pattern Change	If yes, describe change:

Describe how sleeplessness is handled:

Walking/Movement Activity	☐ No Problems		
☐ *** Tremors**	☐ *** Gait**	☐ *** Weakness**	☐ *** Paresis**
☐ *** History of Falling**	If yes, describe problem:		
☐ *** Assistive Devices**	If yes, describe devices used (cane, walker, prosthesis, etc.):		
☐ **** Limited ROM**	If yes, describe range of movement limitations:		
☐ *** Amputation**	If yes, describe amputation:		
☐ **** Recent Change in functional mobility**	If yes, describe change:		
☐ Regular Exercise	If yes, describe type(s) and amount of exercise:		
☐ Other Problems			

W A R N I N G

*** (or) ** = implement FALL / INJURY PREVENTION Protocol**
**** = implement Physician Request for appropriate PT or OT Consult**

Innoculations:	PPD ☐ Y ☐ N Date _____ Treatment _____	Tetanus ☐ Y ☐ N Date _____ Treatment _____	FLU ☐ Y ☐ N Date _____ Treatment _____	Pneumonia ☐ Y ☐ N Date _____ Treatment _____

Reproductive / Menstrual / Sexual History

Sexual Orientation:

☐ Penile Discharge: if checked, describe.	☐ Vaginal Discharge: If checked, describe.	☐ Abnormal Bleeding: If checked, describe.
☐ Contraception	☐ Self Breast Exam	☐ Self Testicular Exam

Last Menstrual Period Date: ☐ Regular ☐ Irregular ☐ Menopausal

Number of Pregnancies:	Number of Live Births:	Number of Miscarriages:	Number of Abortions:

☐ Current Pregnancy	If yes, describe situation:
☐ Infectious Disease History	If yes, describe situation:

PART OF THE MEDICAL RECORD

Section III: Nursing Assessment (continued)

Part A: Physical Status (continued)

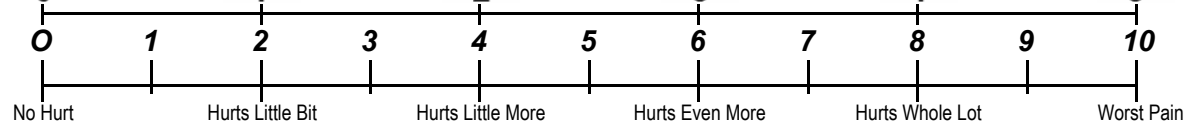
Pain

Acute Pain: ☐ NO ACUTE PAIN	**Chronic Pain:** ☐ NO CHRONIC PAIN
LOCATION:	LOCATION:
INTENSITY: SCALE:	INTENSITY: SCALE:
COMFORT GOAL:	COMFORT GOAL:
QUALITY (Patient's Own Words):	QUALITY (Patient's Own Words):
ONSET: PATTERN:	ONSET: PATTERN:
AGGREVATING FACTORS:	AGGREVATING FACTORS:
ALLEVIATING FACTORS:	ALLEVIATING FACTORS:
IMPACT / Functional Ability:	IMPACT / Functional Ability:
IMPACT / Quality of Life:	IMPACT / Quality of Life:
PAIN MGMNT HISTORY / Helpful	PAIN MGMNT HISTORY / Helpful
PAIN MGMNT HISTORY / Not Helpful	PAIN MGMNT HISTORY / Not Helpful

PAIN SCALES:

WONG-BAKER: *(Faces)*

0-10 VISUAL: *(Numeric)*



VERBAL:

No Hurt — Hurts Little Bit — Hurts Little More — Hurts Even More — Hurts Whole Lot — Worst Pain

NON-COGNITIVE: *Use FLACC Scale* →

WONG-BAKER FACES PAIN SCALE from Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Ahmann E, DiVito-Thomas PA, Whaley & Wong: Care of Infants & Children, 6th ed, St. Louis, MO: Mosby-Year Book Inc., 1999; 1153. Copyrighted by Mosby-Year Book, Inc. Reprinted with Permission.

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 Score
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

PART OF THE MEDICAL RECORD

Safety / Family Violence

Do you feel safe in your living environment? If no, describe situation.

Has anyone hurt you, or in any way (either physically or sexually) forced you to take part in activities against your will? If yes, describe situation.

Have you forced anyone, (either physically or sexually) to take part in activities against their will? If yes, describe situation.

Does the situation change when there are drugs/alcohol involved or changes in someone's mood or mental status? If yes, describe situation.

Would you like assistance with this? ☐ NO ☐ YES (if "YES", contact Social Worker)

☐ DENIES ☐ UNABLE / UNWILLING TO COMMUNICATE ☐ PAMPHLET GIVEN

Coping and Stress

Describe stress in your life (health, relationships, finances, etc.):

Describe recent changes/losses (job, move, new baby, divorce, death, etc.):

What do you when you are under stress?

Have you ever been in: ☐ Seclusion ☐ Restraints

If either box checked, describe situation:

What kinds of things help you to maintain your own control?

What can staff do to assist you in maintaining your own control?

PART OF THE MEDICAL RECORD

Section III: Nursing Assessment (continued)

Part B: Mental Status

ASSAULT AND VIOLENCE ASSESSMENT TOOL

DIRECTIONS: (a) Assess each key factor; (b) Circle one [of three] descriptors for each factor best describing patient; and (c) Add circled items to sum total score.

Key Factors	High Risk - 2 POINTS	Moderate Risk - 1 POINT	No Precautions - 0 POINTS
History of Violence	Any single episode of violence with injury to others while hospitalized -**OR-** Multiple assaults with injury while outside hospital **2**	Destruction of property without injury to others while hospitalized -**OR-** A single assault outside the hospital resulting in injury **-OR-** Multiple assaults outside the hospital not resulting in injury **1**	Violence only when using drugs or alcohol -**OR-** Destruction of property outside the hospital **-OR-** No history of violence. **0**
History of Recent Aggression	Physically threatening at time of referral/admission **2**	Verbally threatening at time of referral/admission **1**	Nonthreatening at time of referral/admission **0**
History of Aggression in Family of Origin	Victim or perpetrator of physical or sexual abuse **2**	Witness of physical or sexual abuse **1**	Witness or victim of verbal aggression **-OR-** No history of aggression in family **0**
Substance Abuse Status	Recent alcohol/substance abuse activity detoxing -**OR-** Currently under the influence of alcohol or drugs **2**	Recent substance/alcohol abuse with absence of withdrawal symptoms **1**	Rehabilitated abuser -**OR-** No history of alcohol/substance abuse **-OR-** Past history (>3 months ago) alcohol/substance abuse with no rehabilitation **0**
Paranoia / Hostility	Paranoia or hostility generalized to people in the immediate environment **2**	Paranoia or hostility generalized toward inaccessible people **1**	No apparent paranoia No apparent hostility **0**
Impulsivity	Physically impulsive **2**	Verbally impulsive **-OR-** History of physical impulsivity **1**	No apparent impulsivity **0**
Agitation	Psychomotor agitation with constant pressured physical activity **2**	Psychomotor agitation with intermittent bursts of hyperactivity **1**	No apparent psychomotor agitation **0**
Sensorium	Disoriented with impaired memory **2**	Oriented with impaired memory **1**	Oriented with intact memory **0**
Scoring Key	**9 or more = High-risk precautions**	**3 to 8 = Moderate-risk precautions**	**0 to 2 = No precautions**

Total Score: _____ **Assessed by (RN):** _____ **Date:** _____ **Time:** _____

ASSAULT and VIOLENCE ASSESSMENT TOOL (Courtesy of Psychiatric Nursing, Institute of Psychiatry, Medical University of South Carolina).

Reason for Admission

Describe reason for admission including severity and duration of illness:

PART OF THE MEDICAL RECORD

Psychiatric Unit

Section III: Nursing Assessment (continued)

Part B: Mental Status (continued)

Previous Psychiatric Treatment

Dose /

Describe when, where and why patient reports receiving previous psychiatric treatment. Include an assessment of long-term memory.

Appearance

Describe appearance including consistency with age, personal habits, manner of dress, behavior, eye contact, speech, movement, gait, posture, level of consciousness, state of health and reaction to the interview:

Emotional State

Describe the affect or observed emotional state:

Describe the mood or emotional state reported by the patient:

Thought Process

Clarity of Meaning or Association			
☐ No Problem Noted			
☐ Coherent	☐ Incoherent	☐ Confused	☐ Unclear
☐ Other _____			

Content of Thought			
		☐ No Problem Noted	☐ Homicidal Ideations
☐ Hallucinations	☐ Delusions	☐ Feelings of Unreality	☐ Obsessions
☐ Compulsions	☐ Phobias	☐ Grandiosity	☐ Preoccupations
☐ Ideas of Reference	☐ Ideas of Influence	☐ Confabulations	☐ Neologisms

Describe alterations:

PART OF THE MEDICAL RECORD

Section III: Nursing Assessment (continued)

Part B: Mental Status (continued)

SUICIDE/SELF-HARM ASSESSMENT TOOL

DIRECTIONS: (1) Answer Question I; (2) Complete Section II by circling one of the three descriptors for each Key Factor that BEST describes the patient; (3) Complete Section III; (4) Add the points for each circled item in Sections I, II, and III to obtain the total score.

Question I.	High Risk - 2 POINTS	Moderate Risk - 1 POINT	No Precautions - 0 POINTS
Is the current admission precipitated by a suicide attempt?	Yes **2**	No **1**	**0**
Section II.	**High Risk - 2 POINTS** ***(1:1)***	**Moderate Risk - 1 POINT** ***(q15min observation)***	**No Precautions - 0 POINTS**
Contract for safety	Unwilling to contract -**OR-** Unable to contract because of impaired reality testing (hallucinations, delusions, dementia, delirium, disassociation) **2**	Contracts but is ambivalent or guarded **1**	Reliably contracts for safety **0**
Suicide plan	Has plan with actual or potential access to planned method **2**	Has plan without access to planned method **1**	No plan **0**
Plan lethality	Highly lethal plan (gun, hanging, jumping, carbon monoxide) **2**	Low lethality of plan **1**	Low lethality of plan (superficial scratching, head banging, pillow over face, biting, holding breath) **0**
Elopement risk	High elopement risk **2**	Low elopement risk **1**	No elopement risk **0**
Suicidal ideation	Constant suicidal thoughts **2**	Intermittent or fleeting suicidal thoughts **1**	No current suicidal thoughts **0**
Attempt history	Past attempts of high lethality **2**	Past attempts of low lethality **1**	No previous attempts **0**
SYMPTOMS (check those that apply) ☐ HOPELESSNESS ☐ HELPLESSNESS ☐ ANHEDONIA ☐ GUILT / SHAME ☐ ANGER / RAGE ☐ IMPULSIVITY	5 - 6 symptoms present **2**	3 - 4 symptoms present **1**	0 - 2 symptoms present **0**
Current morbid thoughts (reunion fantasies, preoccupation with death)	Constantly **2**	Frequently **1**	Rarely **0**
Section III.	**Replies Not Trustworthy**	**Replies Questionable**	**Replies Trustworthy**
RN's subjective appraisal of Patient's Reliability	Pt. Replies not trustworthy; several nonverbal cues **4**	Pt. Replies questionably, trustworthy; at least one nonverbal cue **3**	Pt. Replies trustworthy **0**
SCORING KEY	**10 or more = High-risk Precautions** ***(1:1)***	**4 to 9 = Moderate-risk Precautions** ***(q15min observation)***	**0 to 3 = No Precautions**

Total Score: _____ **Assessed by (RN):** _____ **Date:** _____ **Time:** _____

SUICIDE / SELF-HARM ASSESSMENT TOOL (Courtesy of Psychiatric Nursing, Institute of Psychiatry, Medical University of South Carolina).

PART OF THE MEDICAL RECORD

Section III: Nursing Assessment (continued)

Part B: Mental Status (continued)

Flow of Thought	☐ No Problem Noted		
	☐ Lack of Spontaneity	☐ Slow Reaction to Questions	☐ Loose Associations
☐ Doubting and Indecisive	☐ Flight of Ideas	☐ Thought Blocking	☐ Thought Insertion
☐ Thought Withdrawal	☐ Circumstantiality	☐ Tangentiality	☐ Perseveration
☐ Poverty of Thought Content	☐ Echolalia	☐ Word Salad	☐ Clang Associations

Describe:

Cognitive Functioning

Mini-Mental State

	Maximum Score	Patient Score
Orientation		
What is the: (year), (season), (date), (day), (month)? **[Score below 5 is *Initiate Fall Protocol]**	**5**	
Where are we: (state), (country), (town), (hospital), (floor)?	**5**	
Registration		
Name three objects at a pace of one per second. Ask the patient to repeat all three objects named. Give one point for each object named. If the patient has not named all three objects, repeat the process until the patient can name all three. Record the number of trials it takes: _____	**3**	
Attention and Calculation		
Use Serial 7's, stopping after 5 answers. Alternatively, ask the patient to spell "world" backwards. Give one point for each correct answer.	**5**	
Recall		
Ask the patient to repeat all three objects previously named. Give one point for each object named.	**3**	
Language		
Point to a pencil and ask the patient to name the object. Repeat with a watch. Give on point for each object named.	**2**	
Ask the patient to repeat the following statement: "No if's, ands or buts." Give one point if repeated correctly.	**1**	
Ask the patient to follow these directions: "Take a paper in your right hand, fold it in half and put it on the floor." Give one point for each direction followed.	**3**	
Write the following statement on a piece of paper. "Close your eyes." Give the patient the paper and ask the patient to follow the directions on the paper. Give one point if the patient follows the directions.	**1**	
Ask the patient to write a sentence. Give one point.	**1**	
Ask the patient to copy a design. Give one point.	**1**	
TOTAL SCORE	**30**	

Fund of Knowledge: (ask one)

☐ Name 5 cities in the USA.

☐ Name the current President and 2 other past Presidents.

☐ Name the capital of either Maryland or Virginia.

Response:

PART OF THE MEDICAL RECORD

Section III: Nursing Assessment (continued)

Part B: Mental Status (continued)

Abstract Thinking: (ask one)

- ☐ Birds of a feather flock together.
- ☐ A stitch in time saves nine.
- ☐ Don't count your chickens before they hatch.

Response:

Insight: (ask: "Why do you think you are here at the hospital?")

Response:

Judgment: (ask one)

- ☐ Why do they put criminals in jail?
- ☐ What would you do if you got through the line in the grocery store and found out you had no money?
- ☐ What would you do if you found a stamped, addressed envelope on the street?

Response:

Signature, Title and Credentials of Registered Nurse Completing Section III	Date and Time of Completion of Section III