UNIVERSITY MEDICAL CENTER

SHORT STAY ADMISSION PROFILE

Treatment Area: ❒ CSDAR ❒ SAS ❒ MDAR

❒ Other : _____ Addressograph

Valuables

	N/A	Sent Home	Placed in Safe	Remains at Bedside	Other
Dentures					
Eyeglasses					
Hearing Aid					
Clothing					
Other:					
Other:					

Valuables: *I fully understand that HUMC is not responsible for any personal property brought in or retained at the bedside at anytime. I fully understand that HUMC provides a safe for my valuables should I wish to place them there for the duration of my hospital stay.*

_____ _____

Signature of Patient/Significant Other *Witness*

Section IA

ALLERGIES: ❒ Denies ❒ Latex ❒ Contrast Dye ❒ Food: _____

❒ Medications: _____

❒ Other: _____

❒ Other: _____

Explain Reaction: _____

Medications

Name or Purpose	Dose/Route/Frequency

Section IB

Last Dose	Left at Home	Sent Home	To Pharmacy

Able to swallow pills? ❒ Yes ❒ No

Explain: _____

Oxygen: ❒ No ❒ Yes* Method: _____

Respiratory Treatments: ❒ No ❒ Yes* Type: _____

Section IA & Section IB **Completed by:** _____ *(signature)* _____ *(title)* **Date/Time:** _____

Section II

Advance Directive:

❒ No
❒ Yes, Copy on Chart ❒ Yes, Copy Requested from: ❒ Patient/Family ❒ MD ❒ Medical Records
❒ Information Requested ❒ Information Given

Reason for Admission/Chief Complaint: _____

Transferred From/Admitted From: ❒ Home ❒ Homeless* ❒ Other*: _____

Transferred via: ❒ Wheelchair ❒ Stretcher ❒ Ambulatory

Work #: _____

Emergency Contact this admission _____ *Home #:* _____
Name *Relationship*

Recent Infections or Exposures: *(within the last month)* ❒ Denies ❒ Chicken Pox ❒ Herpes Zoster/Shingles ❒ T.B.
❒ Other: _____

❒ Understands English ❒ Reads English **Primary Language:** _____
❒ Speaks English ❒ Interpreter Required (if other than English)

Hendrich Fall Risk Model - Assessment Tool

Risk Factors	Points
Recent History of Falls	+7 PT eval/screen
Depression	+4
Altered Elimination	+3
Confusion/Disorientation	+3

Risk Factors (contd.)	Points
Dizziness/Vertigo	+3 PT eval/screen
PoorJudgement	+3
Poor Mobility/Generalized Weakness	+2
TOTAL INITIAL RISK SCORE	

KEY	
0 - 2	Normal/Low Risk
3 - 6	Level 1/High Risk
More than 6 PT eval/screen	Level 2/Extremely High Risk

Score ≥3 Requires Fall Prevention Identification

Health History

Medical/Surgical History (including dates): ❒ Denies Past Medical History/Surgical History

❒ **Seizures**
❒ **Stroke/TIA**
❒ **Asthma**
❒ **COPD**
❒ **Aspiration Pneumonia**
❒ **Tuberculosis**
❒ **Recent Upper Respiratory Infection**
❒ **Sleep Apnea**
❒ **Thyroid Disorder**
❒ **Angina**
❒ **Pacemaker**
❒ **M.I.**
❒ **Hypertension**
❒ **Heart Failure**
❒ **Valve Disease**
❒ **Heart Murmur**
❒ **Irregular Rhythm**
❒ **Heart Disease**
❒ **High Cholesterol**
❒ **Circulation Problems**
❒ **Peripheral Vascular Disease**
❒ **Hiatus Hernia**
❒ **Ulcers**
❒ **Gastrointestinal Problems**
❒ **Hemorrhoids**
❒ **Pancreatitis**
❒ **Hepatitis**
❒ **Liver Disease**
❒ **Renal Disease**
❒ **Prostate Problems**
❒ **Gynecological Problems**
❒ **Sexually Transmitted Disease**
❒ **Diabetes**
❒ **Glaucoma**
❒ **Communicable Disease**
❒ **HIV***
❒ **Cancer**
❒ **Blood Disorder**
❒ **Pain**
❒ **Muscular Disorders**
❒ **Spine Disease**
❒ **Arthritis**
❒ **Fractures**
❒ **Emotional Illness**
❒ **Blood Transfusions**
❒ **Transfusion Reactions**
❒ **Skin Disorders**
❒ **Surgery**
❒ **Bleeding Disorders**
❒ **Substance Abuse**
❒ **Pressure Ulcer:** _____
❒ **Other:** _____
❒ **Other:** _____
❒ **Significant Family history:** _____
❒ **Smoking history:** _____
❒ **ETOH history:** _____

Actual Weight: _____

Anesthesia History: ❒ Uneventful ❒ Other: _____

Further Explanations ***(ie. Treatment, surgery)***

_____
_____
_____
_____

**** PLACE REFERRAL TO APPROPRIATE DISCIPLINE***

Health History continued

If 65 or older, date of last Flu Vaccine _____ ❒ Never received **Pneumonia Vaccine** _____ ❒ Never received

LMP: _____ **Gravida:** _____ **Para:** _____ **could you be pregnant?** _____ *(when indicated)*

Do you use complementary medical therapies: ***(i.e., chiropractor, massage, acupuncture, herbs, vitamins)***

❒ Yes ❒ No If yes, explain: _____

_____

Vision: ❒ No difficulty reported ❒ Impaired: _____

Hearing: ❒ No difficulty reported ❒ Impaired: _____

Mental Status: ❒ No deficit observed ❒ Impaired: _____

Do you need assistance with ADLs: ❒ No ❒ Yes

Explain: _____

_____

Section III - Pain History Assessment:

PAIN INTENSITY SCALE – 0 - 10

0	1-3	4-7	8-10
None	Mild	Moderate	Severe

PAIN HISTORY ASSESSMENT:

Do you have pain now? ❒ Yes ❒ No Intensity: _____

Describe: _____

Have you had pain in the last several weeks or months? ❒ Yes ❒ No Intensity: _____

Describe: _____

Is your pain related to your admission today? ❒ Yes ❒ No

How do you express pain? _____

What pain medications has or has not relieved your pain in the past? _____

_____

If current or past pain intensity ≥ 4, continue with pain assessment.

LOCATION OF PAIN: Mark site with letter A or B if more than one site

PAIN SITE:

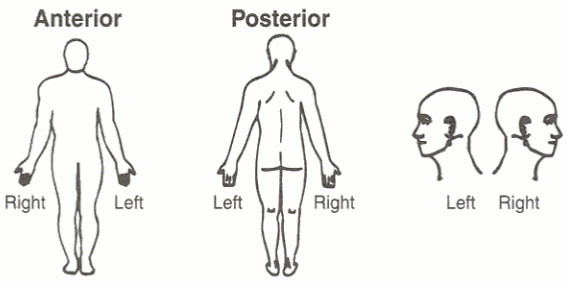
Location of Pain _____

Appearance of Pain Site _____

Worst Pain Felt (Intensity Score) _____

Least Pain Felt (Intensity Score) _____

Qualities (ache, dull, burn, sharp, etc.) _____



*** PLACE REFERRAL TO APPROPRIATE DISCIPLINE**

Section III - Pain History Assessment continued:

ONSET/DURATION:

When did your pain begin? _____

How long is the pain episode? _____

Is it constant or does it come and go? _____

Does the pain radiate? If yes, where _____

What causes or increases the pain? _____

What relieves the pain? _____

_____

_____

What accompanies the pain? (dizziness, nausea, anxiety, etc.) _____

Do you feel pain interferes with your everyday life/activities? If yes, How? _____

_____

_____

PATIENT/FAMILY GOALS

❒ **Complete Relief** ❒ **Acceptable level of pain** _____

❒ **Other** _____

Section IV - Initial Discharge Assessment:

Refer to discharge planning if home environment is inconsistent with patients needs, or patient required services prior to admission (ie. O2, parental/enteral feeding) or there is concern with home environment supporting safe patient care.

Do you have an adult who will be escorting you home and be with you through the night? ❒ Yes ❒ No If no describe plan

_____

Based on obtained patient information and nursing assessment - referral related to discharge needs made to:

❒ Discharge Planning* ❒ Other: _____ ❒ None Required

Post Procedure phone call made: (when indicated) ❒ Yes ❒ No

Comments: _____

_____

_____

❒ Patient/Family advised that Social Service/Discharge Planning can be contacted after discharge.

REFERRALS/DISCIPLINES TELEPHONE EXTENSIONS:

Discharge Planning	**2299**
Respiratory	**2333**
Social Services	**2110**

Section V - Teaching

Is there anything you would like to learn about your health? _____

How do you learn best? ❒ Demonstration ❒ Reading ❒ Video ❒ Discussion ❒ Other: _____

Learning Needs: ❒ Disease Process _____ ❒ Diagnostic Tests/Procedures: _____

❒ Surgical Procedures: _____

❒ Perioperative Process: _____ ❒ Medications: _____ ❒ Diet: _____

❒ Pain Management Plan: _____

Other: _____

Section II thru Section V **Completed by:** _____ *(signature)* _____ *(title)* **Date/Time:** _____

*** PLACE REFERRAL TO APPROPRIATE DISCIPLINE**