UNIVERSITY MEDICAL CENTER

ADMISSION PROFILE

Date ____________________________

<table>
<thead>
<tr>
<th>Valuable</th>
<th>N/A</th>
<th>Sent Home</th>
<th>Placed in Safe</th>
<th>Remains at Bedside</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cane/Walker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglasses</td>
<td></td>
<td></td>
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</table>

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</thead>
<tbody>
<tr>
<td>Hearing Aid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
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</tbody>
</table>

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 valuable(s) should I wish to place them there for the duration of my hospital stay.

Signature of Patient/Significant Other __________________________________________

Witness __________________________________________

Section 1 - General Information

Information obtained from: ☐ Patient ☐ Family/Significant Other

Reason for Admission / Chief Complaint: __________________________________________

Transferred from / Admitted From: ☐ Home ☐ Homeless ☐ Other / Facility Name: __________

ALLERGIES: ☐ Denies ☐ Latex ☐ Contrast Dye ☐ Food: _____________________________

☐ Medications: __________________________________________________________________________

☐ Other: _________________________________________________________________________________

Explain Reaction: ____________________________________________________________

Advance Directive:

☐ No ☐ Yes, Copy on Chart ☐ Yes, Copy Requested from: ☐ Patient/Family ☐ Physician ☐ Medical Records

☐ Information Requested ☐ Information Given

Emergency Contact This Admission:

_____________________________________________________________________________________

Name ____________________________ Relationship ____________________________ Home # __________ Work # __________

☐ Understands English ☐ Speaks English ☐ Reads English ☐ Interpreter Required ☐ Primary Language ____________________________ (if other than English)

Immunization Status:

If 50 or older, date of last Flu Vaccine __________________ ☐ Never received ☐ Unable to recall

If 65 or older, date of Pneumococcal Vaccine __________________ ☐ Never received ☐ Unable to recall

If patient states they never received vaccines or they are unable to recall, give appropriate Vaccine Information Sheet and initiate influenza and/or pneumococcal vaccine standing orders on discharge. Not Applicable for Bone Marrow or Organ Transplant Patients

Infectious Disease History: ☐ Denies ☐ T.B. ☐ Other: __________________________

ADMISSION PROFILE MEDICAL RECORD PAGE 1 REV. 9/29/05
Section 2 - Health History

Pertinent Medical / Surgical History: ☐ No

Patient Admitted with a Pressure Ulcer: ☐ Yes  ☐ No  If yes, document on the Pressure Ulcer Documentation Record

Outpatient Services: ☐ No  ☐ Dialysis  ☐ Radiation Oncology  ☐ Cancer Center

Other: 

Anesthesia History: ☐ Uneventful  ☐ Other: ________________

Section 3 - Cognitive/Sensory Perception

Vision: ☐ No difficulty reported  ☐ Impaired: ________________  ☐ Glasses  ☐ Contacts  ☐ Other: ________________

Hearing: Do you have difficulty hearing even when a speaker faces you and speaks louder? ☐ Yes  ☐ No

If yes, complete Form #5013811 and obtain an assistive listening device from Distribution

Hearing Aids ☐ In Use  ☐ Left Home  ☐ Not Working  If not working change battery (available in Distribution) or refer to family/significant other.

Section 4 - Pain History Assessment

PAIN INTENSITY SCALE - 0 - 10

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Hurt</td>
</tr>
<tr>
<td>1-3</td>
<td>Hurts Little Bit</td>
</tr>
<tr>
<td>4</td>
<td>Hurts Little More</td>
</tr>
<tr>
<td>6</td>
<td>Hurts Even More</td>
</tr>
<tr>
<td>8</td>
<td>Hurts Whole Lot</td>
</tr>
<tr>
<td>10</td>
<td>Hurts Worst</td>
</tr>
</tbody>
</table>

Pain Scale for Non-Communicative Patient

1 - 2  Sleeping, calm / relaxed, not agitated
3 - 4  Grimacing with movement
5 - 6  Moaning with movement
7 - 8  Restless
9 - 10 Constant moaning without stimuli

Do you have pain now? ☐ Yes  ☐ No  Intensity: ________________ Describe: ________________

What is an acceptable level of pain to you in order to continue your activities of daily living? ________________

If current pain intensity is 4 or higher than patient's acceptable level of pain, continue with pain assessment on flowsheet.
Section 5 - Psychosocial

**Tobacco:** [ ] Yes [ ] No How Long?: __________________ Type: __________________ Amount: __________________

- Have you smoked or has someone in your house smoked in the last year? [ ] Yes [ ] No [ ] Patient Refused
- If yes, would you like: [ ] Information on Smoking Cessation (Creenotes) [ ] Referral to a Smoking Cessation Program/Counseling (ext. 8908)

**Alcohol:** [ ] Yes [ ] No Do you drink every day? [ ] Yes [ ] No If no, how often? __________________

- Amount of drinks per day: __________ Last Drink: __________

**Emotional Illness:** [ ] Yes [ ] No Dx: __________________

**Illicit Drug Use:** [ ] Yes [ ] No Type: __________________ Last Use: __________________

- Are you currently in a **physical or emotionally abusive** relationship? [ ] Yes [ ] No Specify: __________________

If yes to Daily Alcohol, Emotional Illness, Illicit Drug Use, or Physical / Emotional Abuse refer to Social Service Ext. 2110
- Referral Called: __________________

- Do you have any special needs we should be aware of? __________________ [ ] None Requested

- Cultural needs/considerations affecting hospitalization and plan of care: __________________ [ ] None Requested

- Spiritual resources requested (Ext. 2345): __________________ [ ] None Requested

Section 6 - Depression Screen

In the past month have you been bothered a lot by:
- [ ] Trouble sleeping (# _______ hours slept per night)
- [ ] Little interest or pleasure in doing things
- [ ] Feeling down, depressed or hopeless
- [ ] "Nerves" or feeling anxious or on the edge
- [ ] Worrying about a lot of different things

- If the patient has 2 or 3 of the above symptoms, discuss the plan of care to address these issues with the primary physician.
- If the patient has 4 or 5 symptoms, or answers that he/she is feeling down, depressed, or hopeless, ask the patient,

"Do you have thoughts of harming yourself?"

- Select the patient's answer below:
  - [ ] Patient denies thoughts of harming self
  - [ ] Patient states YES to thoughts of harming self

- If the patient answers YES, ask: "What would you do to harm yourself?"

- Select answer below:
  - [ ] Thoughts of harming self but denies intent
  - [ ] Thoughts of harming self and has intent

- If YES to either question:
  - Initiate 1:1 arms length observation monitoring and notify doctor immediately and request he/she call for psychiatric consultation (Ext. 3535)
  - Initiate Protocol for Care of Patient who is High Risk for Suicide, Self Injury, Violence Toward Others and or Property.

Section 7 - Teaching

Readiness to Learn: [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Preferred Learning Style</th>
<th>Potential Barriers to Learning</th>
<th>Learning Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Visual</td>
<td>[ ] None</td>
<td>[ ] Diagnosis</td>
</tr>
<tr>
<td>[ ] Written</td>
<td>[ ] Desire/Motivation</td>
<td>[ ] Safe Use of Equipment</td>
</tr>
<tr>
<td>[ ] Demonstration</td>
<td>[ ] Physical Limitations</td>
<td>[ ] Medications</td>
</tr>
<tr>
<td>[ ] Learning Deficiency:</td>
<td>[ ] Limited Learning Ability</td>
<td>[ ] Community Resources</td>
</tr>
<tr>
<td>[ ] Other</td>
<td>[ ] Religious</td>
<td>[ ] Nutrition/Diet</td>
</tr>
</tbody>
</table>

Sections 1-7 Completed By: __________________ Signature: __________________ Title: __________________ Date/Time: __________________

ADMISSION PROFILE MEDICAL RECORD PAGE 3 REV. 9/29/05
### Section 8 - Activity / Safety

**Hendrich Fall Risk Model - Assessment Tool**

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent History of Falls</td>
<td>+7 PT eval/screen</td>
</tr>
<tr>
<td>Depression</td>
<td>+4</td>
</tr>
<tr>
<td>Altered Elimination</td>
<td>+3</td>
</tr>
<tr>
<td>Confusion/Disorientation</td>
<td>+3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Factors (cont’d.)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness/Vertigo</td>
<td>+3 PT eval/screen</td>
</tr>
<tr>
<td>Poor Judgement</td>
<td>+3</td>
</tr>
<tr>
<td>Poor Mobility/Generalized Weakness</td>
<td>+2</td>
</tr>
</tbody>
</table>

**TOTAL INITIAL RISK SCORE**

**KEY**

<table>
<thead>
<tr>
<th>Score</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 2</td>
<td>Normal/Low Risk</td>
</tr>
<tr>
<td>3 - 6</td>
<td>Level 1/High Risk</td>
</tr>
<tr>
<td>More than 6</td>
<td>Level 2/Extremely High Risk</td>
</tr>
</tbody>
</table>

**PERFORMANCE OF ADL**

- Trouble feeding self/opening jars and containers  
  - Yes  
  - No
- Difficulty with Dressing  
  - Yes  
  - No
- Difficulty with Personal Hygiene  
  - Yes  
  - No

If yes to any of the above questions is a change from the pre-admission level then enter OT Eval/Screen into IDX Order # ____________

### Section 9 - Nutrition

- Special Diet at Home  
  - Yes  
  - No

Would you like information about your diet?  
- Yes  
- No

If YES, enter CONSULT for Nutrition Education in IDX  
Order #: ____________

**High Nutrition Risk Criteria**

**ANY HIGH RISK DIAGNOSIS OR YES ANSWER TO THE QUESTIONS BELOW INDICATES HIGH NUTRITION RISK AND REQUIRES REFERRAL VIA THE IDX-LASTWORD SYSTEM**

**High Risk Diagnosis & Current Physical Findings:**

- Breast Feeding/Pregnancy not on maternity units  
  - Yes  
  - No
- Renal Failure
- Dysphagia
- Homeless  
  - Yes  
  - No
- Other

- Supplements (i.e., Ensure) / Tube Feed / TPN
- Newly diagnosed Diabetes
- Pressure Ulcer - Stage II or greater
- Dehydration
- Eating Disorder

**Weight History**

- Actual Weight
- Stated Weight
- Stated Height

Unintentional weight change - 10 lbs. in last 3 months?  
- Yes  
- No

Unintentional weight change - 5% in last 3 months?  
- Yes  
- No

Reason:

| Reduce intake (less than 1/2 of usual for last 5 days)  | Yes  
| No |
|--------------------------------------------------------|-----|
| Diarrhea (< 3 days)  
  - Yes  
  - No |
| Vomiting (>3 days)  
  - Yes  
  - No |

**Referral for High Nutritional Risk entered into IDX?**  
- Yes  
- No

Order #: ____________

### Section 10 - Initial Discharge Assessment - Ext. 2299

Refer to case management if home environment is inconsistent with patient’s needs or patient required services prior to admission or there is concern with home environment supporting safe patient care.

**Previous Home Care Services:**  
- Yes  
- No

Does patient live alone?  
- Yes  
- No

If yes to either question, refer to Case Management

**Referral?**  
- Yes  
- None Required

**Sections 8-10 Completed By:**  
**Signature**  
**Title**

**Date/Time:** ____________

**ADMISSION PROFILE**  
**MEDICAL RECORD**  
**PAGE 4**  
**REV. 9/29/05**