ADULT
ADMISSION ASSESSMENT

Date ________________________ Time ________________________ Addressograph

Person to Notify in Case of Emergency:
Name ________________________ Phone ________________________ Relationship ________________________

Orientation to Nursing Unit:
Nurse Call System ( ) Crib / Side Rails ( ) Bathroom ( ) Phone ( )
No Smoking ( ) No leaving children unattended ( ) Bed Controls ( )
ID Bracelet ( ) TV Controls ( ) Visiting Hours ( ) Patient Information ( )

Questions for Patient:
*Advanced Directives Durable POA Healthcare Surrogate
*Organ Donor Patient Rights Information Reviewed
Patient Voice Understanding of Above
*If no, information given

Admitted from:
Home ( ) ER ( ) Swingbed ( ) Surgery ( )
Nursing Home ( ) MD Office ( )

Admitted via:
Stretcher ( ) Ambulatory ( ) Wheelchair ( ) Parent's Arms ( )

Chief Complaint: ________________________

Vital Signs: Temp _______ Pulse _______ Has received tx for this condition prior to admission ( ) Yes ( ) No
Resp _______ B/P _______ If yes, explain: ________________________

Disposition of Valuables
Caldwell County Hospital will not assume responsibility for lost or damaged valuables, clothing, or personal
items kept in the patient’s possession. Valuables should be taken home or secured by the hospital.
( ) Valuables taken home ( ) Valuables secured by hospital* ( ) No valuables with patient
*See valuables envelope for description. Envelope # ________________________
Patient / Family Signature ________________________
Witness Signature ________________________ Date ________________________ Time ________________________

Valuables picked up by ________________________

Witness ________________________ Date / Time ________________________

Health Profile: Informant: ( ) Patient ( ) Other ________________________

Disposition of Medication: ( ) Left at Home ( ) Stored at Nurses Station ( ) At Bedside
Sent home with ________________________

Have you been hospitalized at our facility in the past 7 days? ( ) Yes* ( ) No
*If yes, has there been any changes in your status since last admission? ( ) Yes* ( ) No
*If yes, COMPLETE ASSESSMENT; if no, copy previous assessment and attach to this assessment.
Medical History and Previous Surgery: ( ) Heart ( ) Diabetes ( ) Seizures ( ) HTN ( ) GI
( ) Thyroid ( ) Neuro ( ) EENT ( ) Musculoskeletal ( ) Cancer ( ) GU ( ) Pulmonary / Respiratory
( ) Vascular ( ) Psychological / Mental
Explain___________________________

Ever had a blood transfusion? ( ) Yes* ( ) No *If yes, when: ___________________________

Social / Environmental Assessment:
1. Patient lives: ( ) Alone ( ) With family ( ) At home ( ) Nsg home ( ) With S/O
2. Habits: ( ) Tobacco
( ) Alcohol
( ) Recreational Drugs
3. Education: Last grade in school attended: (please circle)

   Can read? ( ) Yes ( ) No
   Can write? ( ) Yes ( ) No
4. Is Home Health involved in your Care? ( ) Yes ( ) No
5. Abuse / Neglect / Exploitation Screen
   Yes No Questions
   ( ) ( ) Do you feel unsafe in your home?
   ( ) ( ) Are you afraid of anyone?
   ( ) ( ) Have you ever been physically, sexually or emotionally abused?
   ( ) ( ) Within the past year, have you ever been hit, slapped, kicked, or otherwise physically hurt?
   ( ) ( ) Have you ever been touched in a manner that makes you feel uncomfortable?

If yes is checked on any of the above items, consult Police, Social Services and notify the MD.

Social Services Contact: __________________________ Time: __________________________

Physical Assessment (Must be completed by an RN)

Skin
   Color Impairment: ( ) None ( ) Pallor
   ( ) Flushed ( ) Cyanosis ( ) Jaundice
   ( ) Other
   Temperature: ( ) Warm ( ) Hot ( ) Cool
   Turgor: ( ) Good ( ) Fair ( ) Poor
   Impairment of Skin: ( ) Yes* ( ) No
   *If yes, describe / mark location on diagrams:

Oral / Dental / Nasal
   Teeth Condition: ( ) Good ( ) Fair ( ) Poor ( ) N/A
   Dentures: ( ) Upper ( ) Lower ( ) Partial ( ) Complete
   ( ) With Patient ( ) Not with Patient
   Gums: ( ) Pink ( ) Pale ( ) Inflamed ( ) Bleeding
   ( ) Moist ( ) Dry
   Nose: ( ) Nosebleeds ( ) Drainage ( ) No problems
   Describe

Hygiene
   Bathing: ( ) Minimal Assist ( ) Partial Assist ( ) Complete
   Condition on arrival: __________________________
   Oral Hygiene: ( ) Self ( ) Assist ( ) Complete
   Condition on arrival: __________________________
   Hair Condition: __________________________
Neuro Status
( ) Conscious ( ) Semiconscious ( ) Unconscious
( ) Alert ( ) Oriented to: ( ) Person ( ) Place ( ) Time
Weakness / Paralysis: ( ) None ( ) Left Arm ( ) Right Arm ( ) Left Leg ( ) Right Leg
Range of Motion: ( ) Independent ( ) Requires Assistance

Pupils / Eyes
Pupils: ( ) Equal ( ) Unequal: R < L or L < R ( ) Reactive ( ) Nonreactive: R L
Eyes: ( ) Drainage: R L Describe:

Vision
( ) Adequate ( ) Decreased: R L ( ) Blind: R L ( ) Cataracts: R L ( ) Prosthesis: R L
( ) Glasses / Contacts: ( ) With Patient ( ) Not with Patient

Speech / Swallowing
Speech: ( ) Clear ( ) Easily Understood ( ) Slurred ( ) Partially Understandable
( ) Cannot be Understood
Swallows: ( ) Without Difficulty ( ) With Difficulty ( ) Chokes on Saliva ( ) Chokes on Liquids
( ) Chokes on Solids

Hearing / Ears
Hearing: ( ) Adequate ( ) Decreased: R L ( ) Hearing Aid: R L ( ) With Patient
( ) Deaf: R L ( ) Uses Sign Language ( ) Reads Lips ( ) Communicates through writing
Ears: Drainage: R L Describe:

Mobility
( ) Independent ( ) Needs Minimal Assist ( ) Needs Significant Assist ( ) Requires Total Assist
( ) Uses Crutches ( ) Uses Walker ( ) Uses Wheelchair ( ) Uses Cane,
( ) With Patient ( ) Not with Patient
( ) Uses Limb Prosthesis ( ) With Patient ( ) Not with Patient

Respiratory / Cardiovascular
Respiratory Problems: ( ) None ( ) Wheezing ( ) Stridor ( ) Dyspnea ( ) Hemoptyis
( ) Cough ( ) Nonproductive ( ) Productive Describe:
Duration:
( ) Dyspnea ( ) Exertional ( ) At Rest
( ) Irregular Breathing Pattern:
Breath Sounds:
Aids to Respiration: ( ) None ( ) Oxygen at Home: Amt. / Del. Method
Neb Txs at Home ( ) Suctioning ( ) Tracheostomy ( ) Other
Cardiovascular Problems: ( ) None ( ) Chest Pain - Frequency / Duration / Precipitating & Alleviating Factors:
( ) Cyanosis ( ) JVD ( ) Irregular Pulse / Rhythm ( ) Other
Cardiovascular Aids: ( ) Pacemaker: ( ) Demand ( ) Fixed Rate
( ) Implanted Defibrillator ( ) Other

Elimination
Bowel Status:
Bowel Sounds:
<table>
<thead>
<tr>
<th></th>
<th>LUQ</th>
<th>RUQ</th>
<th>LLQ</th>
<th>RLQ</th>
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<tbody>
<tr>
<td>Present</td>
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<tr>
<td>Absent</td>
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<tr>
<td>Hyperactive</td>
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<tr>
<td>Hypoactive</td>
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</table>
Frequency of BM: ( ) Daily ( ) BID ( ) QOD Other:
( ) Formed Stool ( ) Constipation ( ) Diarrhea: Color:
Date of last BM:
Bowel Problems: ( ) None ( ) Pain ( ) Flatulence ( ) Change in Bowel Habits
( ) Bloody Stools ( ) Rectal Drainage ( ) Incontinence ( ) Hemorrhoids ( ) Other
Abdomen: ( ) Soft ( ) Firm ( ) Tender ( ) Non-Tender ( ) Distended ( ) Non-Distended

Urinary Status:
Problems: ( ) None ( ) Cloudy Urine ( ) Foul Smell ( ) Dysuria ( ) Hematuria ( ) Nocturia
( ) Incontinence ( ) Stress ( ) Constant ( ) Urgency / Frequency ( ) Retention ( ) Burning
( ) Pain Other:
( ) Ostomy ( ) Self Cath: Frequency
( ) Indwelling Foley - date last changed: ____________________________ ( ) Palpable Bladder
Female
Currently Pregnant: ( ) Yes ( ) No ( ) NA
( ) Menses Problems: ____________________________
Date of last Menstrual Period: __________________
( ) Vaginal Discharge: ____________________________

Male
( ) Prostate Problems
( ) Problems establishing Urine Stream
( ) Penile Discharge: ____________________________
( ) Hx STDs: ____________________________

Comfort / Rest / Sleep
Sleep
( ) No Problems ( ) Awakens Frequently ( ) Unable to Fall Asleep Easily
( ) Requires Sleeping Medication - Med / Dose / Frequency
Avg. # Hrs. Slept Each Night ________ # Pillows used _______

Other: Male / Female: ____________________________

Comfort / Pain
Is the patient currently having pain or admitted with a pain related diagnosis? ( ) Yes ( ) No
If yes, complete this section.
Intensity (circle appropriate pain intensity level)

Rating on Pain Scale

<table>
<thead>
<tr>
<th>Pain Intensity Level</th>
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<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>None</td>
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</tbody>
</table>

Location: ____________________________
Duration: ____________________________ ( ) Continuous ( ) Intermittent
( ) Chronic - > 6 months ( ) Acute - < 6 months
Type: ( ) Ache ( ) Sharp ( ) Dull ( ) Shooting ( ) Stabbing ( ) Burning ( ) Pressure
( ) Cramping ( ) Other: ____________________________
Relieved by: ( ) Rest ( ) Heat ( ) Cold ( ) Position ( ) Activity
( ) Meds: ____________________________ ( ) Other: ____________________________
Aggravated by: ____________________________

Do you have any personal, cultural, spiritual and/or ethnic beliefs that may affect the way your pain is treated?
( ) Yes ( ) No If yes, explain: ____________________________

Psychological Status
Body Image / Self Concept Problems: ( ) None Identified at this time ( ) Signs / Symptoms of Depression
( ) Suicidal Ideations ( ) Other: ____________________________

Observation of Patient Behavior / Interaction: ( ) Cooperative ( ) Anxious ( ) Withdrawn ( ) Restless
( ) Calm ( ) Uncooperative ( ) Unresponsive

Spiritual Needs: ( ) Yes ( ) No Requests Minister, etc. be notified: ( ) Yes ( ) No
Minister's Name / Phone No. ____________________________

Discharge Needs
( ) Housing ( ) Physical Care ( ) Housekeeping ( ) Meals ( ) Finances ( ) Transportation
( ) Home Health ( ) Nursing Home Placement ( ) None Identified at this time
( ) Discharge Planner Notified

Plan of Care Reviewed with:
( ) Patient ( ) Family ( ) Significant Other
**FALL RISK ASSESSMENT**

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
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<tbody>
<tr>
<td>Confused, disoriented, hallucinating, combative</td>
<td>20</td>
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<tr>
<td>Unstable gait, weakness</td>
<td>20</td>
</tr>
<tr>
<td>Hx of syncope, seizures, postural hypotension</td>
<td>20</td>
</tr>
<tr>
<td>Recent hx of falls</td>
<td>20</td>
</tr>
<tr>
<td>Use of restraints</td>
<td>20</td>
</tr>
<tr>
<td>Paralysis, hemiplegia, stroke, TIA</td>
<td>15</td>
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<tr>
<td>Post-op condition, sedated</td>
<td>10</td>
</tr>
<tr>
<td>Impaired vision</td>
<td>10</td>
</tr>
<tr>
<td>Drug or alcohol withdrawal</td>
<td>10</td>
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<tr>
<td>Use of walker, cane (other assistive aids)</td>
<td>10</td>
</tr>
<tr>
<td>Narcotics, diuretics, antihypertensives, hypnotics, tranquil, poly-pharmacy</td>
<td>10</td>
</tr>
<tr>
<td>Bowel, bladder urgency, incontinent</td>
<td>10</td>
</tr>
<tr>
<td>Equipment with risk for entanglement (IV's, C2, feeding tubes, etc.)</td>
<td>10</td>
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<tr>
<td>Age 70 or above</td>
<td>10</td>
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<tr>
<td>Age 12 or below</td>
<td>5</td>
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<tr>
<td>Language barrier</td>
<td>5</td>
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<tr>
<td>Poor hearing</td>
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**SCORE**

- **High Risk Interventions Implemented (Initial)**

A score of **35** or above may indicate the patient is at high risk for falling. These patients at high risk for fall shall have the following interventions implemented. Nursing shall monitor these at least every 2 hours.

- Visually observe patient every 2 hours. If awake, offer comfort measures and toileting.
- Instruct patient and/or family to ask for assistance for any patient activities.
- All items for patient's use will be within easy reach.
- Reassess for safe footwear.
- Reinforce use of assistive devices, if used.
- Reassess for a clutter free, well-lit environment.
- Re-orient and repetitively reinforce use of call bell. Ensure it is within reach.
- Consider a room closer to the nursing station.
- Utilize the Bed Check Alarm System / chair alarms.
- Utilize high-risk identification including green dots on wristband, door chart and near room number on the nurse call system.
Date: ____________________________  Height: ____________________________  Weight: ____________________________

Allergies (Medications, OTCs, Food, Environmental) & Type of Reaction:

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Pregnant? ( ) Yes ( ) No

EDC

Lactating? ( ) Yes ( ) No

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<thead>
<tr>
<th>Current Medications / Herbs / Vitamins / OTC Meds</th>
<th>Dose</th>
<th>Frequency</th>
<th>Last Dose</th>
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Date: ____________________________

Physical Therapy Screen

Within the last 7 days, functional status has changed resulting in an inability to complete:  □ ADLs  □ Transfers  □ Ambulation independently or with minimal assistance.

Date: ____________________________

Nutritional Screen

Special diet at home:

Dietary likes / dislikes:

□ Weight change of 20 lbs. in past 3 months  □ NOP > 24 hours

□ Obesity > 300 lbs.

□ Hasn’t eaten for more than 2 days  □ Loss of appetite

□ Altered taste sensation

□ Special dietary restrictions  □ Hx of > one major chronic illness

□ Difficulty Swallowing  □ Excessive Thirst  □ Nausea / Vomiting

□ Hematuria / Hematemesis  □ Persistent Diarrhea  □ Pregnant / Lactating

□ Cultural, Ethnic, Religious Food Preferences

Date: ____________________________

Speech Screen

Speech:  □ Clear  □ Easily Understood  □ Slurred  □ Partially Understandable

□ Cannot be Understood

Swallows:  □ Without Difficulty  □ With Difficulty  □ Chokes on Saliva

□ Chokes on Liquids  □ Chokes on Solids

Nurse’s Signature ____________________________  Date / Time ____________________________