Swing Bed Services

ADMISSION ASSESSMENT

DEMOGRAPHICS

Patient Name _____ Patient Number _____

Sex: Male or Female Birthday _____ Age _____

Diagnosis _____

_____

Physician _____ Diet _____

Location of patient prior to admission _____

Responsible Party _____

Immediate Contacts	Relationship	Telephone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

LEISURE INTEREST / SKILL SURVEY

Social Status: Married Widowed Divorced Single Other

No. of Children _____ Grandchildren: _____

Family Relationships: Stable Unstable Comments: _____

_____

Open to Visitors: Yes No Prefers: Single Groups

Any Activity Precautions: _____

Hobbies, Interests & Skills

✓ = Present + = Past

Drawing	_____	Ceramics	_____	Quilting	_____
Knitting	_____	Sewing	_____	Crocheting	_____
Wood Work	_____	Cross-Stitch	_____	Embroidery	_____
Crewel	_____	Needlepoint	_____	Latch Hook	_____
Flower Arranging	_____	Collecting	_____	_____	_____

Other _____

MUSIC

Country	_____	Gospel	_____	Classical	_____
Pop	_____	Soft Rock	_____	Instrumental	_____
Sing	_____	Play	_____	_____	_____

DANCE

Social	_____	Square	_____	Watch	_____

DRAMA

Act	_____	Watch	_____	_____	_____

READ

Newspaper	_____	Magazines	_____	Fiction	_____
Non-Fiction	_____	Bible	_____	Plays	_____
Large Print	_____	Talking Books	_____	_____	_____

GAMES

Horseshoes	_____	Bingo	_____	Puzzles	_____

Other _____

SPORTS

Played_____ Watch_____

COMMENTS

_____

_____

_____

_____

_____

ASSESSMENT

Check all that apply

Physical Status

Amputation	_____	Contracture	_____	Decubitus	_____
Incontinent	_____	Paralysis	_____	Dentures	_____
Glasses	_____	Hearing Aid	_____	_____	_____

Impairments

Hearing	_____	Sight	_____	Speech	_____
Endurance	_____	Strength	_____	_____	_____
ADL Ind.	_____	Assistance	_____	Total Care	_____

Mobility

Ambulatory	_____	Independent	_____	With Assist	_____
With Walker	_____	With Cane	_____	Wheelchair	_____
Bedrest	_____	Up in Chair	_____	Outings Permitted	_____

Behavior

Alert & Oriented	_____	Confused	_____		
Cooperative	_____	Uncooperative	_____	Withdrawn	_____

SOCIAL ASSESSMENT

Previous Living Arrangements _____

_____

Work History / Retirement _____

_____

Religious Affiliation _____ Pastor _____

Active or Inactive

Available Support Systems: Family Friends Church

Other _____

Patient's Current Level of Care Needs _____

Current Identified Strengths _____

Limitations _____

Problems / Weaknesses _____

DISCHARGE PLAN

Rehabilitation Potential: Excellent Good Fair Poor

Projected Discharge Plans _____

_____

_____

_____

_____

Projected Social Service Needs

Patient _____

Family _____

Projected Special Needs at Time of Discharge

Diet _____

Therapy _____

Wound Care _____

Medications _____

Educational Needs _____

Environmental Needs _____

Goals for Discharge: (circle)

Self Care Family Care HH Services

Nursing Home Placement Community Resources

Rehabilitation Unit Home with Hired Help

Referral agencies contacted? Yes No N/A

If yes, list agency, date of contact and expected outcome. _____

_____

_____

Also see nursing discharge assessment / patient instructions.

Additional Notes

_____

_____

_____

_____

Date _____

SB Coordinator or Designee _____