**Memorial Hospital**

**PATIENT ADMISSION DATA BASE**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Mode</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Religious Preference:**

- [ ] Ambulatory
- [ ] Stretcher
- [ ] Wheelchair

**Marital Status:**

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Widowed

**Lives With:**

- [ ] Spouse
- [ ] Family
- [ ] Alone
- [ ] Other

**Emergency Contact / Relation:**

- [ ] House
- [ ] Apartment
- [ ] Extended Care
- [ ] Homeless
- [ ] Other

**Information Obtained From:**

- [ ] Admitting
- [ ] ED
- [ ] Patient
- [ ] Family

**NURSE’S INITIALS**

### FUNCTIONAL ASSESSMENT (May be completed by an RN or LPN)

#### HEALTH PERCEPTION / HEALTH MANAGEMENT

**Reason for Admission:**

- [ ] Diabetes
- [ ] Lung Disease
- [ ] TB
- + PPD
- [ ] Glaucoma
- [ ] Hypertension
- [ ] Renal Disease
- [ ] Coronary Disease
- [ ] Vascular Disease
- [ ] Epilepsy
- [ ] Other

**Surgical History:**

- [ ] N / A
- [ ] Intact
- [ ] Other

**Operative Site:**

- [ ] N / A
- [ ] Jaw Problems:
- [ ] N / A

**Anesthesia Reaction:**

- [ ] N / A
- [ ] Neck Problems:
- [ ] N / A

**Reproductive Health:**

- Last Menstrual Period:
- Last Self Breast Exam:
- Last Pap Smear:
- Pap Smear Offered:
- Refused

**Self Testicular Exam:**

**Prostate Screen (> 40 yr):**

**Any sexual concerns?**

**Smoking History:**

- What:
- How Much:
- How Long:
- Last Use:

**Would you like information about how to quit smoking?**

- [ ] Yes
- [ ] No

**Info Given:**

- [ ] Yes
- [ ] No

**Alcohol History:**

- How Much:
- How Long:
- Last Drink:

**Street Drugs:**

- How Much:
- How Long:
- Last Use:

**Are you taking any over the counter medications? (Include herbs, vitamins & laxatives)**

- [ ] Yes
- [ ] No

**What medicine do you use for pain and is it effective?**

- [ ] Yes
- [ ] No

**MEDICATIONS**

<table>
<thead>
<tr>
<th>Medication / Strength</th>
<th>Freq.</th>
<th>Last Dose</th>
</tr>
</thead>
<tbody>
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</table>

**ALLERGIES (Med, Food, Other)**

<table>
<thead>
<tr>
<th>List Allergies / Type of Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**VITAL SIGNS / WEIGHT**

<table>
<thead>
<tr>
<th>BP:  L:</th>
<th>BP:  R:</th>
<th>P:</th>
<th>R:</th>
<th>T:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>HEIGHT:</th>
<th>WEIGHT:</th>
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</thead>
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</table>

| Disposition of Medication: |
| Did Not Bring |
| Sent Home |
| Other |

### DISCHARGE PLANNING

If patient answers “yes” to any question, refer to Case Management, ext 2240.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>SPECIFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Will living arrangements be a problem after discharge?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>B. Do you have anyone at home who is dependent on you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Do you currently have home health care?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a preference for a home health care provider? Name:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>D. Do you currently have or have ever had medical equipment at home? Type:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a preference for a medical equipment provider? Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Will you need help from any community agencies for counseling, family planning, Meals on Wheels, etc.?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Do you need information on entitlement (Medicare, Medicaid, Social Security, Disability, etc.)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Will you need information on Physical therapy, Rehabilitation, Nursing homes or Assisted living?</td>
<td></td>
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</tbody>
</table>

**NURSE’S INITIALS**
FUNCTIONAL ASSESSMENT

COGNITION - PERCEPTION
If in need of an interpreter - call Volunteer Services - 2507.
Hearing impaired or Deaf - call Case Management - 2240
Able to Read English: □ Yes □ No
Primary Language if Not English
Name and Number of Interpreter

Memory Problem (short or long term, transient): □ Yes □ No If Yes, Describe:
Vision Impairment: □ Right □ Left □ Both
Hearing Impairment: □ Right □ Left □ Both Hearing Aid: □ Yes □ No With Patient: □ Yes □ No
Alteration in Sensory Perception: □ Yes □ No Describe:
Speech Impairment: □ Yes □ No If yes, contact MD for a referral.

SLEEP / REST / ACTIVITY
Sleep / Rest Pattern (times of day, amount, difficulties, routines, aids, etc.):
Usual Activities / Exercise Pattern (exercise routine, kind, frequency, leisure activities, occupation):

Activities with Which You Usually Need Help:
□ Eating □ Dressing □ Bathing □ None
□ Cooking □ Walking □ Climbing Stairs □ Other
Assistive Devices: □ Wheelchair □ Cane □ Walker □ Crutches
Gait: □ Not Ambulatory □ Bedridden □ Steady □ Unsteady

Does patient's current functional status differ significantly since onset of current health problem? □ Yes □ No
If yes, request PT and/or OT referral from MD.

INITIAL PAIN ASSESSMENT

This assessment can be completed by the patient or Nurse. (The assessment must be reviewed by a RN)
RN Reviewed ____________ Person Completing Form ____________

1. Do you have pain today or have you had pain in the last several months? □ No □ Yes (If the patient answers yes, please proceed with the assessment)
2. LOCATION: Mark the location(s) with an X where you hurt the most.
   Right □ Left □
3. Please select a pain scale from the 3 choices shown below that the patient would prefer to use. If pain exists today, rate the pain on the scale selected.
   □ 0 - 10 SCALE:
   □ FACES:
   □ WORD DESCRIPTOR: (WD)

4. What number would you circle as a comfort goal? (This is not the most pain tolerable, but a number where you could move around, walk, cough and deep breath and recover quicker.)
   □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
5. QUALITY: □ Aching □ Burning □ Throbbing □ Cramping □ Numbness □ Prickling □ Sharp
6. What time of day is your pain the worst? □ Morning □ Afternoon □ Evening □ Bedtime □ Constant □ N/A
7. What causes / aggravates the pain? (Check all that apply)
   □ Sitting □ Bending □ Walking □ Standing □ Flexing / Extending □ Other □ N/A
     □ Medication □ Rest □ Elevation □ Activity □ Ice / Heat □ Other □ N/A
9. What makes the pain better? (Check all that apply)
   □ Medication □ Rest □ Elevation □ Activity □ Ice / Heat □ Other □ N/A
   □ Appetite / Weight □ Physical Activity □ Sleep □ Other □ N/A
10. Does pain interfere with any of the following? (Check all that apply)
    □ Appetite / Weight □ Physical Activity □ Ability to Concentrate □ Relationships with Others □ Sleep □ Mood / Emotions □ N/A

ELIMINATION

Urinary Elimination / Alterations:

- None
- Frequency
- Urgency
- Pain / Burning
- Other:

Time Last Voided: [NURSES INITIALS]

Sewal Elimination Alterations:

- None
- Constipation
- Diarrhea
- Bleeding
- Hemorrhoids
- Laxative / Enema Use
- Other:

Last BM:

[NURSES INITIALS]

EMOTIONAL WELL-BEING

The phone extension for the Chaplain is 2708.

How are you feeling? Sad / Depressed: [ ] Yes [ ] No
Anxious: [ ] Yes [ ] No

What are your usual methods of dealing with problems / stress?

Have you ever sought professional help for your problems? [ ] Yes [ ] No Specify:

Do you have any concerns about your ability to maintain your religious / spiritual / cultural practices / beliefs during your hospitalization?

[NURSES INITIALS]

NUTRITIONAL - METABOLIC

Dentures: [ ] Upper [ ] Lower [ ] None [ ] Partial
Diet before Admission:

Nutrition Screening (give each factor that applies a score of "1")

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Score</th>
<th>Risk Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Weight</td>
<td>D. TPN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Unscheduled weight loss of 10 lb or more within 3 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gready underweight / overweight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pressure ulcer present or at risk to develop</td>
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</table>

Patients with a score of one or more requires a nutrion assessment by a Dietitian.

Notify the Nutritionist - Ext 2354
Call Doctor for SLP - Chewing or Swallowing Difficulty

[FALL RISK ASSESSMENT]

Each of the following equals 1 point

- Age 70 or older
- Urinary / bowel - incontinence
- Chronic debilitation disease
- Use of drugs affecting blood pressure / mental status, unatention / delirium
- Sensory deficit
- Postural hypotension
- Depression / hopelessness
- Neurological dysfunction / mobility deficit

SCORE

Total points

SCORE

Each of the following equals 3 points

- Chronic / delirious confusion
- Unsteady gait
- History of prior falls

TOTAL POINTS

Due to condition:

BELONGINGS / ADVANCE DIRECTIVES

Check appropriate box:

- Glasses
- Contact Lenses
- Dentures: [ ] Upper [ ] Lower [ ] None [ ] Partial
- Caps: [ ] Upper [ ] Lower [ ] None [ ] Partial

ADVANCE DIRECTIVES / LIVING WILL (AD / LW)

- Informed / Bill of Rights:
- Face Sheet Completed for AD / LW:
- Information Given AD / LW:
- Does Pt have AD / LW:
- If yes, do you have a copy with you?
- If no, can someone bring in a copy?
- If you do NOT have your AD with you, would you like the doctor to document your directives in your medical record?

If yes, NOTIFY PHYSICIAN

Copy AD / LW Obt from old chart, signed by Pt
Deemed more info. AD / LW
Does Pt have a durable power of attorney for healthcare
Organ / Tissue Donation:

ORGANIZATION

- Room
- Bed
- Phone
- Call Light / TV
- Safety
- Bathroom Call Light
- Visiting Hours
- Smoking Policy

Oriented to:

- Patient reminded to retain no more than $5.00 at bedside.

[NURSES INITIALS]
PHYSICAL ASSESSMENT (Must be completed by an RN)

NEUROLOGICAL

Consciousness: □ Alert □ Lethargic Oriented To: □ Person □ Place □ Time

Respond Appropriately to Questions: □ Yes □ No Explain:

Speech: □ Clear □ Slurred □ Aphasic Explain:

Pupils: □ Equal □ React Unequal: □ R > L □ L > R

Moves All Extremities Equally: □ Yes □ No Explain:

Strength of All Extremities: □ Strong □ Weak □ Absent

CARDIO-PULMONARY

Respiratory Effort: □ Easy □ Laborated

Cough: □ None □ Yes Sputum: □ Yes □ No Color:

Breath Sounds: Apical Pulse: Rate: Rhythm: Pedal Pulse: R: L: Describe:

Capillary Refill: □ Not Applicable □ Brisk □ Sluggish

GASTROINTESTINAL / GENITOURINARY

Abdomen: □ Soft □ Non-tender □ Tender Location:

□ Firm □ Non-distended □ Distended Girth:

Bowel Sounds: □ Present □ Absent Bladder: □ Non-distended □ Distended □ Catheter Care: □ Independent □ Needs Assistance

Ostomies: Type:

INTEGUMENTARY (Braden Scale MUST be completed on Skin Assessment Flow Sheet, Form 90-5936)

Skin Color: □ Pink □ Ashen □ Mottled □ Jaundiced □ Pale □ Flushed □ Cyanotic

Temperature: □ Warm □ Cool □ Hot □ Cold / Clammy

Turgor: □ Resilient □ Tenting

Edema: Describe location and degree (1-4+)

(Braden Scale MUST be completed on Skin Assessment Flow Sheet, Form 90-5936)

SUMMARY STATEMENT

REFERRALS:

□ Case Management Date: □ Discharge / Placement □ AD / LW □ Nutrition Date:

□ Chaplain Date: □ Diabetic Date: □ PT / OT (Request from MD) Date:

□ Psych (Request from MD) Date: □ Other: □ SLP Date:

□ Skin / Wound Care Date: □ Other:

□ Notify MD / PA / NP of Patient's Arrival: □ Yes Time: □ Plan of Care: □ Yes

Unable to complete because:

RN Signature for Physical Assessment: Date & Time:

INIT SIGNATURE / TITLE INIT SIGNATURE / TITLE