NAME OF HOSPITAL

Nursing Admission Assessment

Date: _____Time: _____
Informant: ☐ Patient ☐ Other _____ Phone #: _____
Mode of access: ☐ Ambulatory ☐ WC ☐ Stretcher ☐ Other _____
Transported with ☐ Oxygen ☐ Monitor ☐ IV ☐ Other _____
From: ☐ Home ☐ ER ☐ Dr. Off. ☐ AFC ☐ ECF ☐ Other _____ Accompanied by: _____
Valuables: ☐ None ☐ Sent home with _____ ☐ Lock-up
Reason for Admission (Pt's own words): _____
_____
_____

Vital Signs

T	O R A T	P	Reg Irreg	SaO_2	R	BP	Ht	Wt	S B W/C	Kg

Allergies

Allergies	Reaction	Allergies	Reaction	Allergies	Reaction
Latex? Y or N					

Chronic conditions:

☐ Lung Problems _____ ☐ Stomach Problems _____ ☐ Thyroid Problems _____☐ Neurological Problems_____ ☐ Heart Problems _____ ☐ Liver Problems _____ ☐ Vision Problems _____ __☐ Kidney Problems _____ ☐ Arthritis ☐ Diabetes ☐ Chronic infection _____ Treatment: _____
☐ Cancer (where/type) _____ Treatment: _____
Other Past Medical History or Surgeries: _____
_____
_____
_____
☐ Family history – ☐ NSF ☐ Heart disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease ☐ Liver disease

Medications

Medication (include OTC)	Dose	Frequency	Taken today? Y or N	Brought with? Y or N	Medications (include OTC)	Dose	Frequency	Taken today? Y or N	Brought with? Y or N

Social History

☐ Lives alone ☐ Lives with _____ Stairs at home ☐ Yes ☐ No Sleep pattern _____
Meds sent: ☐ Home with _____ ☐ Lock-up ☐ Not applicable
Immunizations current? Yes _____ No _____ Last Tetanus toxoid? _____
Nicotine Use: ☐ No ☐ Yes – How much? _____ How Long? _____
Instructed on Name of Hospital "No Smoking" Policy? ☐ Yes ☐ No Do you live in a smoking environment? ☐ Yes ☐ No
Alcohol Use: ☐ No ☐ Yes – How much? _____ How Long? _____ Last Drink? _____
Social Drug Use: ☐ No ☐ Yes – Type? _____ Frequency? _____ _____
Support Services: ☐ No ☐ Yes – Type ☐ HHC ☐ Hospice ☐ Other _____
Additional Help needed? ☐ No ☐ Yes – Referral made to _____

Impairment / Disabilities

	Yes	No		Yes	No		Yes	No
Impaired hearing			Hearing Aid	R L		Walker		
Impaired vision			Glasses			Crutches		
Can perform ADL?			Contacts			Wheelchair		
Can read?			Dentures	U L		Cane		
Can write?			Partial			Prosthesis		
			Home O_2	Rate:		Other:		

Dietary Habits

Special Diet: _____ Supplements: _____

Safety

☐ Yes ☐ No ID Band on ☐ Yes ☐ No Oriented to Unit ☐ Yes ☐ No Call Bell in Reach ☐ Yes ☐ No IV pump
☐ Yes ☐ No Toiletry Supplies Offered
Skin Integrity Assessment Scale: _____ if 17 or below, Skin Risk intiated
Fall Risk Assessment Scale: _____ if above 25, Fall Prevention initiated

Skin Risk Assessment Scale

Sensory Perception Ability to respond to pressure related discomfort	**1. Completely limited –** unresponsive to pain or limits ability to feel pain over most of body	**2. Very limited** – response to painful stimuli or limits ability to feel pain over ½ of body, or paralysis present	**3. Slightly limited** – response to verbal command but can't always communicate	**4. No Impairment** – able to verbalize feelings and complaints
Moisture Skin exposed to moisture	**1. Constantly moist** – (i.e. perspiration, urine)	**2. Very moist** – extra linen change 1x per shift	**3. Occasionally moist** – linen change 1x per day	**4. Usually dry** – no extra linen changes
Activity Degree of physical activity	**1. ABR**	**2. Chair fast** – NWB/WC must be assisted to chair	**3. Ambulates occasionally** – with assist up in chair	**4. Ambulates frequently**
Mobility Ability to change and control body position	**1. Completely immobile**	**2. Very limited** – unable to make frequent changes independently	**3. Slightly limited** – makes frequent slight changes for self	**4. No limitations**
Nutrition Food intake pattern	**1. Very poor** – NPO, Clear liquids, or IVs > 5 days. Takes fluids poorly. Underweight, malnourished.	**2. Inadequate** – eats < ½ meal. Takes less than optimum	**3. Adequate** – eats > ½. Tube feeding or TPN provides needs	**4. Excellent**
Friction	**1. Problem** – requires assist in moving. Frequent friction. History of skin tears or pressure sores	**2. Potential** – requires minimum assist, occasional friction	**3. No apparent problem** – BRP	**4. Up ad Lib**

Fall Risk Assessment Scale

Confused - disoriented - hallucinating	20	Post-op condition - sedated	10	Narcotics, diuretics, antihypertensives, etc.	10
Unstable gait, weakness	20	Drug or alcohol withdrawal	10	Bowel, bladder urgency - incontinence	10
Hx of syncope or seizures	15	Use of walker, cane, crutches, etc.	10	Age 70 or above	5
Recent hx of falls	15	Postural hypotension	10	Uncooperative, impaired judgement	5
Age 12 or younger	15	Poor eyesight	10	Language barrier	5
Paralysis, hemiplegia, stroke	15	New meds (i.e. sedative, antihypertensive)	15	Poor hearing	5

Part II – Systems Review

*** NSF = No significant findings- Check appropriate box if present – if box not checked, sign/symptom not present**

Pediatrics: ☐ NA ☐ NSF

☐ Yes ☐ No Special Diet?_____ ☐ Yes ☐ No Formula _____ Type of Bottle _____ Type of Nipple _____
☐ Yes ☐ No Warmed? ☐ Yes ☐ No Teeth/Teething ☐ Yes ☐ No Feeding Problems _____
☐ Yes ☐ No Diapers ☐ Yes ☐ No Toilet Training Word used for BM _____
☐ Yes ☐ No Immunizations current? ☐ Yes ☐ No Copy to chart?
For children under 2 yrs: Head circ _____ Chest circ _____ Abd Circ _____

Eyes: ☐ NSF

☐ Yes ☐ No Blurred Vision ☐ Yes ☐ No Double vision ☐ Yes ☐ No Inflammation ☐ Yes ☐ No Pain
☐ Yes ☐ No Color blind ☐ Yes ☐ No Itching ☐ Yes ☐ No Pupils abnormal
☐ Yes ☐ No Drainage -- Color _____ Amount _____ ☐ Yes ☐ No Other _____

Ears: ☐ NSF

☐ Yes ☐ No HOH (R) (L) ☐ Yes ☐ No Deaf ☐ Yes ☐ No Tinnitus ☐ Yes ☐ No Dizziness
☐ Yes ☐ No Drainage _____ ☐ Yes ☐ No ↓ sense of balance ☐ Yes ☐ No Pain
☐ Yes ☐ No Other _____

Nose: ☐ NSF

☐ Yes ☐ No Congestion ☐ Yes ☐ No Pain ☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Nasal Flaring ☐ Yes ☐ No Alignment ☐ Yes ☐ No Nosebleeds – frequency _____
☐ Yes ☐ No Drainage – color _____amount _____
☐ Yes ☐ No Other _____

Mouth: ☐ NSF

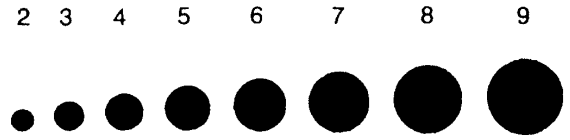
☐ Yes ☐ No Halitosis ☐ Yes ☐ No Pain ☐ Yes ☐ No Bleeding gums ☐ Yes ☐ No Lesions
☐ Yes ☐ No ↓ sense of taste
Dental Hygeine _____ Last Dental Exam _____

Throat/Neck: ☐ NSF

☐ Yes ☐ No Sore throat ☐ Yes ☐ No Hoarseness ☐ Yes ☐ No Lumps ☐ Yes ☐ No Swollen glands
☐ Yes ☐ No Stiffness ☐ Yes ☐ No Pain ☐ Yes ☐ No Dysphagia
☐ Other _____ _____

Neurological: ☐ NSF

☐ Yes ☐ No Cooperative ☐ Yes ☐ No Memory Changes
☐ Yes ☐ No Dizziness ☐ Yes ☐ No Headaches
☐ Yes ☐ No Oriented ☐ Yes ☐ No Other _____
Oriented to: ☐ Yes ☐ No Person ☐ Yes ☐ No Place ☐ Yes ☐ No Time
Pupils Size: _____ Deviation: _____
☐ Yes ☐ No PEARLA
Reaction: ☐ Brisk ☐ Sluggish ☐ No Response



LOC ☐ Alert ☐ Confused ☐ Sedated ☐ Somnolent ☐ Co matose ☐ Agitated ☐ Other _____
Speech ☐ Clear ☐ Slurred ☐ Aphasic ☐ Dysphasia ☐ None ☐ Other: _____
Grips: _____ Foot pushes: _____ Gag reflex: _____ ☐ Other: _____

Respiratory: ☐ NSF

Lung sounds: _____
Dyspnea ☐ None ☐ With activity ☐ At rest ☐ Lying down ☐ Retractions
Cough ☐ None ☐ Non-productive ☐ Productive – Color _____ Amount _____
Chest Symmetry ☐ Yes ☐ No – ☐ Barrel ☐ Funnel ☐ Other _____
☐ Yes ☐ No Night Sweats ☐ Yes ☐ No Hemoptysis ☐ Yes ☐ No Cyanosis – Where _____
☐ Other: _____

Cardiovascular: ☐ NSF

Cardiac Rate or Monitor pattern: _____ ☐ Regular ☐ Irregular ☐ Irregularly irregular
☐ Yes ☐ No Chest Discomfort – Where:_____ Intensity (1 - 10)_____ Onset _____
Duration_____ Resolution _____
☐ Yes ☐ No Pulse Radial (R)/(L) ☐ Yes ☐ No Pulse Pedal (R)/(L) ☐ Yes ☐ No JVD (R)/(L)
☐ Yes ☐ No Edema – Location _____ ☐ Pitting ☐ Non-pitting
☐ Yes ☐ No Pacemaker – Date Inserted _____ Type: _____ Where: _____
☐ Yes ☐ No Murmur _____

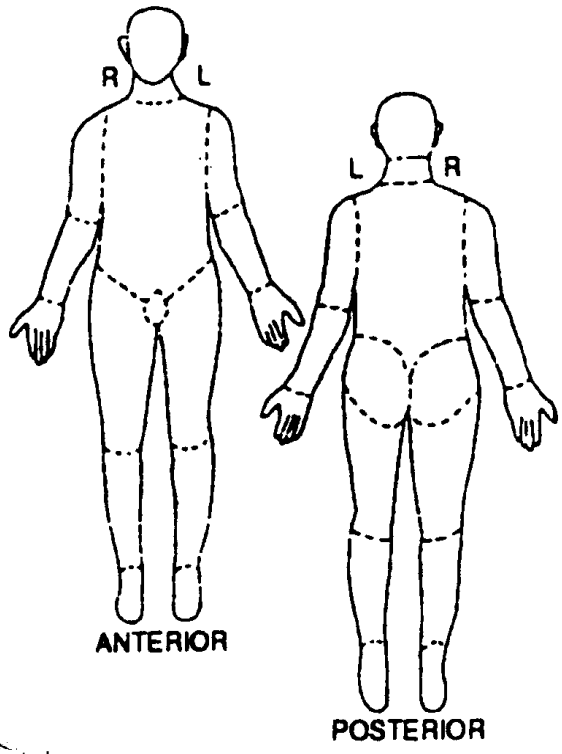
Skin – Extremities – Musculoskeletal: ☐ NSF

Skin ☐ Warm ☐ Cool ☐ Dry ☐ Firm ☐ Flaccid
Color: _____ _____
☐ Yes ☐ No History DVT ☐ Yes ☐ No Homans (R)/(L)
Extremities ☐ Yes ☐ No Tingling ☐ Yes ☐ No Weakness ☐ Yes ☐ No Deformity ☐ Yes ☐ No Contractures _____
Joints ☐ Yes ☐ No Pain ☐ Yes ☐ No Stiffness – Location: _____
☐ Yes ☐ No Replacement – Date _____ Where: _____
ROM ☐ WNL ☐ Other (location/ range): _____

Physical Findings: ☐ **NSF**

Describe and graph all abnormalities by number:

1. Bruises
2. Incisions
3. Lacerations
4. Rashes
5. Decubitus
6. Dryness
7. Scars
8. Lesions
9. Abnormal color
10. Other : _____
11. Tattoos
12. Body Piercing
13. Skin Tear/ Duoderm/Op-Site



Gastrointestinal: ☐ **NSF** **Bowel sounds**

Appetite ☐ Good ☐ Poor ☐ Recent change _____

Last BM Date: _____ Color _____ Frequency: _____

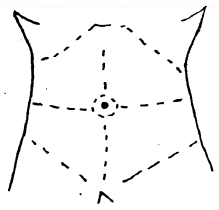
☐ Yes ☐ No Laxative use – Type _____ Frequency _____ How long _____

☐ Yes ☐ No Constipation ☐ Yes ☐ No Diarrhea ☐ Yes ☐ No Nausea ☐ Yes ☐ No Vomiting

☐ Yes ☐ No Distention ☐ Yes ☐ No Hemorrhoids ☐ Yes ☐ No Heartburn ☐ Yes ☐ No Flatus

☐ Yes ☐ No Colostomy ☐ Yes ☐ No Ileostomy ☐ Yes ☐ No Pain ☐ Yes ☐ No Rectal Bleeding

☐ Yes ☐ No Weight gain/loss – Reason: _____



Genitourinary: ☐ **NSF**

Color of urine _____ ☐ Yes ☐ No Odor _____

☐ Yes ☐ No Frequency ☐ Yes ☐ No Flank pain ☐ Yes ☐ No Burning

☐ Yes ☐ No Difficulty starting ☐ Yes ☐ No Urgency ☐ Yes ☐ No Incontinence ☐ Yes ☐ No Itching

☐ Yes ☐ No Nocturia ☐ Yes ☐ No Urostomy ☐ Yes ☐ No Hx of calculi ☐ Yes ☐ No Hx UTI

☐ Yes ☐ No Foley – Date ▵ _____

Reproductive: ☐ **NSF** **FEMALE**

LMP_____ G _____ P _____ A _____ Last PAP _____ ☐ Yes ☐ No Birth control

☐ Yes ☐ No Menopausal – How long? _____ ☐ Yes ☐ No Hormone replacement ☐ Yes ☐ No Lesions

☐ Yes ☐ No Vaginal discharge ☐ Yes ☐ No Itching ☐ Yes ☐ No Dysmenorrhea ☐ Yes ☐ No☐ Amenorrhea

☐ Yes ☐ No Hx STD exposure

Breast ☐ Yes ☐ No Do SBE Monthly? ☐ Yes ☐ No Lumps Last Dr. exam _____ Last mammogram _____

☐ Yes ☐ No Breast feeding ☐ Yes ☐ No Nipple discharge ☐ Yes ☐ No Family Hx

☐ Yes ☐ No Dimpling ☐ Yes ☐ No Symmetry ☐ Yes ☐ No Nipple inversion ☐ Yes ☐ No Pain

MALE

Last prostate exam _____ Last PSA _____ ☐ Yes ☐ No Penile discharge ☐ Yes ☐ No Hernias

☐ Yes ☐ No Sores ☐ Yes ☐ No Testicular lumps ☐ Yes ☐ No Hx STD exposure

Hygiene _____

Breast ☐ Yes ☐ No Pain ☐ Yes ☐ No Lumps ☐ Yes ☐ No Swelling ☐ Yes ☐ No Nipple discharge

Hematological: ☐ **NSF**

☐ Yes ☐ No Bruising ☐ Yes ☐ No Anemia - Hx ☐ Yes ☐ No Anemia - Current ☐ Yes ☐ No Blood Transfusion - Hx

☐ Yes ☐ No Anticoagulant use

Nurse doing Assessment	Date:

Advanced Directive

Does the patient have an Advanced Directive? ☐ No ☐ Yes – Is copy on file? ☐ No ☐ Yes -where? _____
Advanced Directive form on chart? ☐ Yes ☐ No – explain _____
Additional information given? ☐ Yes ☐ No – explain _____

After assessing the above data and interviewing the patient, the R.N. will complete the following:

The following Nursing care plans will be instituted:

_____

_____

_____

_____

_____

_____

_____

_____

Patient would like further information regarding:

☐ **Medication** ☐ **Exercise** ☐ **Mental Health Services** ☐ **Diet** ☐ **Smoking Cessation** ☐ **Weight Control** ☐ **Drug/Alcohol Abuse**

The following educational needs have been identified and will require further follow-up: ____

_____

_____

_____

_____

_____

_____

Patient's / Family's perceived discharge needs (ADLs, meals, etc.):_____

_____

_____

_____

_____

_____

_____Additional Comments:_____

_____

_____

_____

_____

_____

R.N. Signature:

_____

Date: _____ Time:_____