South Tees Hospitals NHS
NHS Foundation Trust

WRITE OR ATTACH ADDRESSOGRAPH
Surname_____
Forenames_____
DOB dd / mm / yyyy Age_____
Hospital number_____
NHS number_____

ADMISSION PROFORMA

CRITICAL CARE SERVICES

Admitted from _____ Planned admission Yes / No

Admitted to Critical Care Unit _____ Date_____ Time _____

Time bed requested _____ Total delay in hours _____ Seen by CCO Yes / No

If admission delayed >1 h, reason for delay _____

Referring Consultant _____

Admitting Consultant Intensivist _____

Parent team/ Specialty Consultant(s) _____

Named Consultant Intensivist _____

ICNARC admission

- ☐ Cardiac massage within 24hrs before admission
- ☐ Cirrhosis – biopsy proven / imaging proven
- ☐ Steroid therapy (≥0.3mg/kg/day)
- ☐ Portal hypertension
- ☐ Radiotherapy (excluding implants)
- ☐ Hepatic encephalopathy
- ☐ Chemotherapy
- ☐ Severe CVS disease (IV)
- ☐ Metastatic disease
- ☐ Severe respiratory disease
- ☐ Home ventilation
- ☐ ALL, AML or Multiple Myeloma
- ☐ CML or CLL
- ☐ Lymphoma
- ☐ AIDS (HIV positive with complications)
- ☐ Chronic renal replacement therapy
- ☐ Congenital humoral or cellular immune deficiency

Actual Weight _____Kg
Date _____
Estimated Weight _____Kg
Height _____cm
BMI _____

NEWS on admission _____
Worst NEWS 24 h prior to admission _____

Clinical Frailty Score (refer to Rockwood chart) _____

PATIENT NAME_____DOB_____HOSPITAL NO. _____

DNACPR Yes / No EHCP Yes / No Advanced Directive Yes / No

PAST MEDICAL HISTORY

SYSTEMIC ENQUIRY

- ☐ SOB
- ☐ Exercise Tolerance
- ☐ Cardiac symptoms
- ☐ Neurological deficit(s)
- ☐ Eyesight
- ☐ Hearing
- ☐ Mouth care / Dentures
- ☐ Communication
- ☐ Mental Health
- ☐ Special dietary needs
- ☐ Assistance to feed need
- ☐ Recent weight loss
- ☐ Continent / Incontinent
- ☐ Catheter in situ (type)
- ☐ Stoma(s)
- ☐ Level of mobility
- ☐ Pain
- ☐ Other

SOCIAL HISTORY

Smoking

Alcohol

Other

Occupation

Religion

Accommodation

Community support

FAMILY HISTORY

Next of Kin - Aware of admission Yes / No

Name

Relation Contact no

Name

Relation Contact no

PATIENT NAME_____DOB_____HOSPITAL NO. _____

MEDICATION PRIOR TO ADMISSION

Information obtained from _____

Name completing _____ Reg no _____

Regular Medication	Dose	Frequency	Action on admission

ALLERGIES

Drug / Substance	Type of reaction

MICROBIOLOGY & IPC ISSUES

PATIENT NAME_____DOB_____HOSPITAL NO. _____

REASON(S) FOR ADMISSION

Date_____ Time _____ Completed by _____ Reg No _____

PATIENT NAME_____DOB_____HOSPITAL NO. _____

EXAMINATION

Date_____ Time _____ Completed by _____ Reg No _____

Respiratory System

Airway: Own / ETT_____ / Tracheostomy _____

Ventilation(circle): Self / NIV / Invasive Ventilation

Interface _____

Ventilation mode _____

Pressures _____

Drains _____

Cardiovascular System

HR _____ Rhythm _____ BP _____

Heart Sounds _____ CVP _____

Peripheral pulses _____

Oedema _____ CRT _____

Cardioactive Drugs

–

–

–

–

Lactate _____

Hb _____

CO Monitoring / Echo

_____

_____

_____

_____

Central Nervous System

Sedated **Y / N**

Drugs _____

_____

Pre sedation GCS ____ /15 E _____ M _____ V

Pupils (*size/reaction*): R _____ L _____

Motor - Cranial _____

- RUL_____LUL_____RLL_____LLL_____

ICP _____ EVD _____

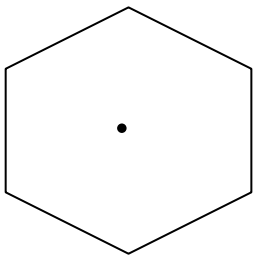
Log roll **Y / N**

Gastrointestinal System

Feeding: Oral / NG / NJ / PEG / Jej-tube / TPN / NBM

Absorbing **Y / N** Glycaemic control _____

Bowels opened **Y / N** _____(when/type)



If indicated, **TRAUMA ADMISSION SUMMARY**

COMPLETED ☐

Musculoskeletal / Skin / Trauma

Pressure areas / Wounds / Rashes

_____

_____

_____

_____

Renal System

Urinary catheter **Y / N**

Urine Output: _____mL /24hrs

24hr fluid balance _____

Cumulative balance _____/_____days

Renal Replacement therapy IHD / CRRT / Other

_____

General / Other

Skin coloration _____

Nutritional status _____

Nodes _____

Other_____

_____

Lines on admission

_____

_____

_____

_____

_____

PATIENT NAME_____DOB_____HOSPITAL NO. _____

DIAGNOSIS / WORKING DIAGNOSIS

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

MANAGEMENT PLAN - ABCDE

Date_____ Time _____ Completed by _____ Reg No _____

INVESTIGATIONS

For childbearing age female patients:

- ☐ Pregnancy test _____
- ☐ β-hCG _____

DISCUSSIONS WITH PATIENT / FAMILY / CARERS *(Date / Time / Sign)*

☐ Tick here if information and discussions on admission is documented elsewhere (i.e., Communication form)

PATIENT NAME_____DOB_____HOSPITAL NO. _____

ADMISSION CHECKLIST

- ☐ ID Bands x2 confirmed
- ☐ Patient admitted in CAMIS
- ☐ Patient admitted on WardWatcher
- ☐ DoS live register completed
- ☐ Valuables recorded:
  - ☐ Property book
  - ☐ Cashiers
  - ☐ Given to relatives
- ☐ MUST Score completed
- ☐ Thromboprophylaxis assessment performed
- ☐ MRSA Screening Chart
- ☐ Moving and Handling Risk Assessment
- ☐ STEP Form
- ☐ Patient diary started
- ☐ Short Clinical Assessment RaCI completed

If indicated:

- ☐ Trauma Admission Summary
- ☐ Sepsis Admission Sumary
- ☐ Urinary Catheter Pathway completed
- ☐ VIP Chart completed
- ☐ Arterial Line Pathway completed
- ☐ Central Line(s) Pathway completed
- ☐ Stool Chart
- ☐ Critical Care Pressure Ulcer Assessment Tool
- ☐ Mental Capacity Assessment

SENIOR REVIEW