

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 initiated
 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

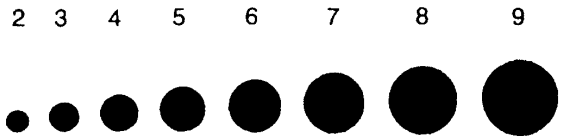
Yes No Halitosis Yes No Pain Yes No Bleeding gums Yes No Lesions
 Yes No ↓ sense of taste
Dental Hygiene _____ Last Dental Exam _____

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: _____
 Yes No Chest Discomfort – Where: _____ Intensity (1 - 10) _____ 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 _____

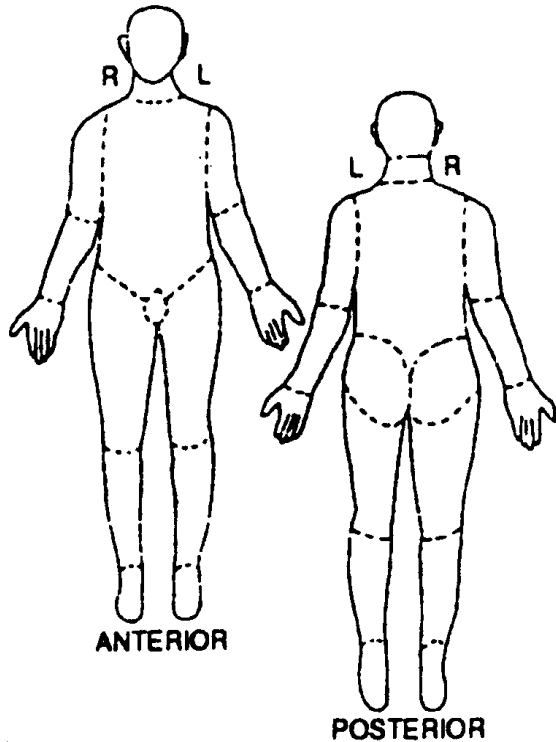
Skin – Extremities – Musculoskeletal: NSF

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:

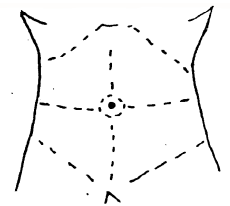
1. Bruises
2. Incisions
3. Lacerations
4. Rashes
5. Decubitus
6. Dryness
7. Scars
8. Lesions
9. Abnormal color
10. Other : _____
11. Tattoos
12. Body Piercing
13. Skin Tear/ Duoderm/Op-Site



Gastrointestinal: NSF

- 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: _____

Bowel sounds



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 Δ _____

Reproductive: NSF

- 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:
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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: _____