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 __________________________
Reason for Admission (Pt’s own words):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Vital Signs

<table>
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<tr>
<th>T</th>
<th>OR</th>
<th>P</th>
<th>Reg</th>
<th>SaO2</th>
<th>R</th>
<th>BP</th>
<th>Ht</th>
<th>Wt</th>
<th>S</th>
<th>Kg</th>
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</thead>
</table>

Allergies

| 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)
Other Past Medical History or Surgeries:
________________________________________________________________________________
________________________________________________________________________________

□ Family history – □ NSF □ Heart disease □ Hypertension □ Diabetes □ Stroke □ Seizures □ Kidney disease □ Liver disease

Medications

<table>
<thead>
<tr>
<th>Medication (Include OTC)</th>
<th>Dose</th>
<th>Frequency</th>
<th>Taken today? Y or N</th>
<th>Brought with? Y or N</th>
<th>Medications (Include OTC)</th>
<th>Dose</th>
<th>Frequency</th>
<th>Taken today? Y or N</th>
<th>Brought with? Y or N</th>
</tr>
</thead>
</table>

Social History

□ Lives alone □ Lives with Meds sent: □ Home with Stairs at home □ Yes □ No Sleep pattern □ Not applicable
□ Immunizations current? Yes □ No □ Lock-up 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
□ Social Drug Use: □ No □ Yes – Type □ Frequency? □ Instructed on Name of Hospital “No Alcohol” Policy? □ Yes □ No
□ Support Services: □ No □ Yes – Type □ HHC □ Hospice □ Other Additional Help needed? □ No □ Yes – Referral made to
### Impairment / Disabilities

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Impaired hearing</td>
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<td>Impaired vision</td>
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<td>Can perform ADL?</td>
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<td>Can read?</td>
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<td>Can write?</td>
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<tr>
<td>Hearing Aid</td>
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<td>Glasses</td>
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<td>Contacts</td>
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<td>Dentures</td>
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<td>Partial</td>
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<tr>
<td>Wheelchair</td>
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<td>Crutches</td>
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<td>Walker</td>
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<td>Other:</td>
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<tr>
<td>Sensory Perception</td>
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<tr>
<td>Moisture</td>
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<td>Activity</td>
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<td>Mobility</td>
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<td>Nutrition</td>
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<td>Friction</td>
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<tr>
<td>Skin Integrity</td>
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<tr>
<td>Fall Risk Assessment</td>
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#### Dietary Habits

**Special Diet:**  
**Supplements:**

#### Safety

- ID Band on: Yes
- No Oriented to Unit: Yes
- Call Bell in Reach: Yes
- IV pump: Yes

**Skin Integrity Assessment Scale:**  
- If 17 or below, Skin Risk initiated
- Fall Risk Assessment Scale:  
- If above 25, Fall Prevention initiated

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>Ability to respond to pressure related discomfort</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completely limited – unresponsive to pain or limits ability to feel pain over most of body</td>
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<tr>
<td>2. Very limited – response to painful stimuli or limits ability to feel pain over ½ of body, or paralysis present</td>
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<tr>
<td>3. Slightly limited – response to verbal command but can’t always communicate</td>
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<tr>
<td>4. No impairment – able to verbalize feelings and complaints</td>
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</table>

<table>
<thead>
<tr>
<th>Moisture</th>
<th>Skin exposed to moisture</th>
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</thead>
<tbody>
<tr>
<td>1. Constantly moist – (i.e. perspiration, urine)</td>
<td></td>
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<tr>
<td>2. Very moist – extra linen change 1x per shift</td>
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<tr>
<td>3. Occasionally moist – linen change 1x per day</td>
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<tr>
<td>4. Usually dry – no extra linen changes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Degree of physical activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ABR</td>
<td></td>
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<tr>
<td>2. Chair fast – NWB/WC must be assisted to chair</td>
<td></td>
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<tr>
<td>3. Ambulates occasionally – with assist up in chair</td>
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<tr>
<td>4. Ambulates frequently</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Ability to change and control body position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completely immobile</td>
<td></td>
</tr>
<tr>
<td>2. Very limited – unable to make frequent changes independently</td>
<td></td>
</tr>
<tr>
<td>3. Slightly limited – makes frequent slight changes for self</td>
<td></td>
</tr>
<tr>
<td>4. No limitations</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutrition</th>
<th>Food intake pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Very poor – NPO, Clear liquids, or IVs &gt; 5 days. Takes fluids poorly. Underweight, malnourished.</td>
<td></td>
</tr>
<tr>
<td>2. Inadequate – eats &lt; ½ meal. Takes less than optimum</td>
<td></td>
</tr>
<tr>
<td>3. Adequate – eats &gt; ½. Tube feeding or TPN provides needs</td>
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<tr>
<td>4. Excellent</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Friction</th>
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</thead>
<tbody>
<tr>
<td>1. Problem – requires assist in moving. Frequent friction. History of skin tears or pressure sores</td>
</tr>
<tr>
<td>2. Potential – requires minimum assist, occasional friction</td>
</tr>
<tr>
<td>3. No apparent problem – BRP</td>
</tr>
<tr>
<td>4. Up ad Lib</td>
</tr>
</tbody>
</table>

#### 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

*NSF = No significant findings-

#### Part II – Systems Review

**Pediatrics:**  
- NA
- NSF

- Yes No Special Diet?  
- Yes No Warmed?  
- Yes No Diapers  
- Yes No Immunizations current?  
- Yes No Feeding Problems  
- Yes No Teeth/Teething  
- Yes No Toilet Training  
- Yes No Copy to chart?  
- Head circ  
- Chest circ  
- Abd Circ

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Page 2 of 5
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
- Speech  □ Clear  □ Slurred  □ Aphasic  □ Dysphasia  □ None  □ Other
- Gags:  □ Foot pushes:
- Other:  □ DVT  □ Agitated  □ 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:  □ Other

Cardiovascular: □ NSF
- Cardiac Rate or Monitor pattern:  □ Regular  □ Irregular  □ Irregularly irregular
- □ Yes □ No Chest Discomfort – Where:
- 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:
- □ Yes □ No Murmur
- Where:

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):

Page 3 of 5
**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: □ How long______________________________

- □ 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  **Incontinence** □ Yes □ No  **Itching**
- □ Yes □ No  **Difficulty starting** □ Yes □ No  **Urgency** □ Yes □ No  **Hx of calculi** □ Yes □ No  **Hx UTI**
- □ Yes □ No  **Nocturia** □ Yes □ No  **Urostomy** □ Yes □ No  **Hx UTI**

**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  **Amenorrhea**
  - □ Yes □ No  **Hx STD exposure** □ Yes □ No  **Dysmenorrhea** □ Yes □ No  **Hx UTI**

  - □ Yes □ No  **Do SBE Monthly?** □ Yes □ No  **Penile discharge** □ Yes □ No  **Hemias**
  - □ 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**

  - **Last prostate exam** ____________________________
  - **Last PSA** ____________________________ □ Yes □ No  **Penile discharge** □ Yes □ No  **Hemias**

  - **Hygiene** □ Yes □ No  **Testicular lumps** □ Yes □ No  **Hx STD exposure**

  - **Breast** □ Yes □ No  **Pain** □ Yes □ No  **Lumps** □ Yes □ No  **Hx STD exposure**

**Hematological:**  □ NSF

- □ Yes □ No  **Bruising** □ Yes □ No  **Anemia - Hx** □ Yes □ No  **Anemia - Current** □ Yes □ No  **Blood Transfusion - Hx**
- □ Yes □ No  **Anticoagulant use**

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Nurse doing Assessment: ____________________________  Date: ____________________________

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Page 4 of 5
<table>
<thead>
<tr>
<th>Advanced Directive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have an Advanced Directive?</td>
</tr>
<tr>
<td>□ Yes – Is copy on file? □ No □ Yes –where?</td>
</tr>
<tr>
<td>Advanced Directive form on chart?</td>
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<tr>
<td>Additional information given?</td>
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</tbody>
</table>

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: ___________________