



**INITIAL PATIENT ASSESSMENT (IPA) - ADULT**

Patient/Resident Label

**Arrival/Entry Data**

Arrival Date: \_\_\_\_\_ Time: \_\_\_\_\_ Identification bracelet on the patient verified as to patient's name and birth date:   
 Patient arrived from:  Home;  E.D.;  OR/PACU/Endoscopy;  Outpatient;  Physician's Office;  Other: \_\_\_\_\_  
 Patient arrived:  Ambulatory;  Wheelchair;  Stretcher.  
 History informant:  Patient;  Other: Whom: \_\_\_\_\_; Relationship: \_\_\_\_\_  
 Contact in case of emergency:  
 Whom: \_\_\_\_\_; Relationship: \_\_\_\_\_; Contact #'s: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

**Vital Signs**

Temperature: \_\_\_\_\_  Oral;  Rectal;  Axillary;  Tympanic; Pulse: \_\_\_\_\_; Respirations: \_\_\_\_\_  
 Blood Pressure: \_\_\_\_\_; SpO<sub>2</sub>: \_\_\_\_\_; Weight: \_\_\_\_\_  Standing Scale;  Bed Scale; Height: \_\_\_\_\_

**Orientation to Environment**

Side Rails;  Bed Controls;  Call Light / Intercom;  Telephone / Television;  Valuables;  No Smoking;  Pastoral Care  
 MCCH Admission Packet: Advance Directives Brochure; Rights & Responsibilities Brochure; Privacy Protection Notice; Speak  
 Up Help Prevent Errors in Your Care Brochure.  Unable to orient to the environment due to patient's condition.

**Belongings/Assistive Devices Brought to Hospital  None**

<input type="checkbox"/> Glasses; <input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Family / Significant Other/Caregiver; <input type="checkbox"/> Patient
<input type="checkbox"/> Dentures; <input type="checkbox"/> Upper; <input type="checkbox"/> Lower	<input type="checkbox"/> Family / Significant Other/Caregiver; <input type="checkbox"/> Patient
<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Family / Significant Other/Caregiver; <input type="checkbox"/> Patient
<input type="checkbox"/> Cane / Crutches / Walker / Wheelchair	<input type="checkbox"/> Family / Significant Other/Caregiver; <input type="checkbox"/> Patient
<input type="checkbox"/> Prosthesis (es); <input type="checkbox"/> Brace(s)	<input type="checkbox"/> Family / Significant Other/Caregiver; <input type="checkbox"/> Patient
<input type="checkbox"/> Equipment:	<input type="checkbox"/> Family / Significant Other/Caregiver; <input type="checkbox"/> Patient
<input type="checkbox"/> Valuables	<input type="checkbox"/> Family / Significant Other/Caregiver; <input type="checkbox"/> Patient; <input type="checkbox"/> Security
<input type="checkbox"/> Medications	<input type="checkbox"/> Family / Significant Other/Caregiver; <input type="checkbox"/> Pharmacy

**Advance Directives Status  Declined**

Type:  DNR;  Living Will;  Healthcare Surrogate;  Durable Power of Attorney;  Organ Donor;  Mental Health AD.  
 Document Location:  Copy placed in medical record;  Not with patient; patient-family-s/o instructed to bring to hospital.  
 If not with patient, write the intent as described by patient-s/o: \_\_\_\_\_

**Allergies and Adverse Drug Reaction(s)  None**

Allergy/ADR: Name of Substance	Reaction	Severity Code	Date
Allergy to <input type="checkbox"/> Iodine; <input type="checkbox"/> Shellfish; <input type="checkbox"/> Latex			
<input type="checkbox"/> Allergy; <input type="checkbox"/> ADR:			
<input type="checkbox"/> Allergy; <input type="checkbox"/> ADR:			
<input type="checkbox"/> Allergy; <input type="checkbox"/> ADR:			
<input type="checkbox"/> Allergy; <input type="checkbox"/> ADR:			

\* Continued on additional sheet and attached to this IPA:

Severity Code Key: S = Severe (rash, hives, anaphylaxis, urticaria); I = Moderate (pruritis); M = Mild (GI upset, n/v/d); U = Unknown

**Present Illness**

See record(s) from  E.D.;  Endoscopy;  Outpatient; *No need to complete this section if records are available from other area as checked.*  
 Admitting diagnosis/chief complaint: \_\_\_\_\_  
 Symptoms/complaints and when started? \_\_\_\_\_  
 Seen by physician/PA/NP prior to arrival?  No;  Yes;  E.D.;  Physician's office.  
 Prior treatment received and duration: \_\_\_\_\_  
 Diagnostic testing? \_\_\_\_\_



<p align="center"><b>Respiratory</b> <input type="checkbox"/> <b>No Relevant History</b></p> <input type="checkbox"/> Chronic cough; <input type="checkbox"/> Asthma; <input type="checkbox"/> TB; <input type="checkbox"/> Emphysema; <input type="checkbox"/> COPD; <input type="checkbox"/> Pneumonia; <input type="checkbox"/> Pulmonary Embolus; <input type="checkbox"/> Cancer; <input type="checkbox"/> Sleep Apnea: Device/Settings: _____/_____ <input type="checkbox"/> O <sub>2</sub> @ home: Liters/minute: _____; Smoker: <input type="checkbox"/> History; <input type="checkbox"/> Present; <input type="checkbox"/> Cigarettes: Packs Per Day: ____; <input type="checkbox"/> Cigars; <input type="checkbox"/> Chewing Tobacco; <input type="checkbox"/> Snuff # of years of tobacco use: _____ <b>Smoking Cessation Referral Initiated:</b> <input type="checkbox"/> ; <b>By Whom:</b> _____	<p align="center"><b>Immunological</b> <input type="checkbox"/> <b>No Relevant History</b></p> <b>Influenza vaccine within past year:</b> <input type="checkbox"/> Yes-Date: _____ <input type="checkbox"/> No-If patient is > 50 y/o or has chronic illness: <b>Physician Referral Initiated:</b> <input type="checkbox"/> ; <b>By Whom:</b> _____ <b>Pneumococcal vaccine within last 5 years:</b> <input type="checkbox"/> Yes-Date: _____ <input type="checkbox"/> No-If patient is > 65 y/o or has chronic illness: <b>Physician Referral Initiated:</b> <input type="checkbox"/> ; <b>By Whom:</b> _____ <b>Last Tuberculin Skin Test?</b> <input type="checkbox"/> Unknown: <input type="checkbox"/> Date: _____ Results: <input type="checkbox"/> Negative; <input type="checkbox"/> Positive. History of HIV: <input type="checkbox"/> AIDS: <input type="checkbox"/> Other: _____ Cancer Treatment: <input type="checkbox"/> Chemotherapy; <input type="checkbox"/> Radiation
<p align="center"><b>Cardiovascular</b> <input type="checkbox"/> <b>No Relevant History</b></p> <input type="checkbox"/> Angina; <input type="checkbox"/> MI; <input type="checkbox"/> Hypertension; <input type="checkbox"/> CHF; <input type="checkbox"/> A-Fib; <input type="checkbox"/> Pacemaker; <input type="checkbox"/> Implantable Defibrillator; <input type="checkbox"/> Angioplasty; <input type="checkbox"/> Stents; <input type="checkbox"/> CABG; <input type="checkbox"/> Mitral Valve Prolapse; <input type="checkbox"/> Palpitations; <input type="checkbox"/> Heart Murmur; <input type="checkbox"/> Other: _____	<p align="center"><b>Musculoskeletal</b> <input type="checkbox"/> <b>No Relevant History</b></p> <input type="checkbox"/> Arthritis; <input type="checkbox"/> Osteoporosis; <input type="checkbox"/> Chronic pain; <input type="checkbox"/> Fracture(s): _____; <input type="checkbox"/> Joint Replacement: _____ <input type="checkbox"/> Foreign body(ies): _____ Use(s): <input type="checkbox"/> Walker; <input type="checkbox"/> Wheelchair; <input type="checkbox"/> Cane; <input type="checkbox"/> Other: _____
<p align="center"><b>Gastrointestinal(GI)/Metabolic/Nutrition</b> <input type="checkbox"/> <b>No Relevant History</b></p> <input type="checkbox"/> GI Ulcer; <input type="checkbox"/> GI Bleeding; <input type="checkbox"/> Diarrhea; <input type="checkbox"/> Constipation; <input type="checkbox"/> GERD; <input type="checkbox"/> IBS/Crohn's*; <input type="checkbox"/> Diverticulitis; <input type="checkbox"/> Hepatitis A, B, C <input type="checkbox"/> Anemia; <input type="checkbox"/> Liver Disease; <input type="checkbox"/> Cancer; <input type="checkbox"/> Hiatal Hernia; <input type="checkbox"/> Hemorrhoids; <input type="checkbox"/> Uses laxatives; <input type="checkbox"/> Unintentional weight loss/ Malnourished* <input type="checkbox"/> On tube feeding or TPN or PPN* <input type="checkbox"/> Inadequate intake* <input type="checkbox"/> Loss of appetite x 1 week* <input type="checkbox"/> Pregnant and/or Lactating* <input type="checkbox"/> Eating Disorder* <input type="checkbox"/> Other: _____ _____* <p><b>If yes to any items with an * initiate a Dietitian referral:</b>  <b>Dietitian Referral Initiated:</b><input type="checkbox"/>; <b>By Whom:</b> _____</p> <input type="checkbox"/> Diabetes- Type: _____; <input type="checkbox"/> Insulin Pump* <input type="checkbox"/> Anemia; <input type="checkbox"/> New diagnosis* <input type="checkbox"/> Has not received OP education in the last year* <input type="checkbox"/> Diagnosis of uncontrolled DM, DKA, HHNK, Hyperglycemia* <input type="checkbox"/> HgbA1C > 7%* <input type="checkbox"/> Polyuria* <input type="checkbox"/> Polydipsia* <input type="checkbox"/> Patient request* Other: _____* <p><b>If yes to any items with an * initiate a Center for Diabetes referral:</b>  <b>Center for Diabetes Referral Initiated:</b><input type="checkbox"/>; <b>By Whom:</b> _____</p> <input type="checkbox"/> Clotting Disorder; <input type="checkbox"/> Thyroid Problem; <input type="checkbox"/> Cancer; <input type="checkbox"/> Blood Transfusion History; Reaction: <input type="checkbox"/> No <input type="checkbox"/> Yes-Type: _____	<p align="center"><b>Genitourinary (GU)/Reproductive</b> <input type="checkbox"/> <b>No Relevant History</b></p> <input type="checkbox"/> Incontinence; <input type="checkbox"/> Kidney Stones; <input type="checkbox"/> UTI; <input type="checkbox"/> Renal Failure; <input type="checkbox"/> Retention; <input type="checkbox"/> Cancer-Type: _____ <input type="checkbox"/> Dialysis-Date of last treatment: _____ <input type="checkbox"/> STD-Type: _____ <b>Female:</b> <input type="checkbox"/> Reproductive problems: _____ <input type="checkbox"/> Performs Self Breast Exams; Last Pap: _____; Last Mammogram: _____ Date of LMP: _____; <input type="checkbox"/> Pregnant; <input type="checkbox"/> Lactating; <b>Male:</b> Last Prostate Screening Exam: _____ Last Testicular Exam: _____ <input type="checkbox"/> Performs Self Testicular Exams; <input type="checkbox"/> BPH; <input type="checkbox"/> Enlarged Prostate; <input type="checkbox"/> Reproductive problems: _____
<p align="center"><b>Integumentary</b> <input type="checkbox"/> <b>No Relevant History</b></p> <input type="checkbox"/> History of skin breakdown (see Physical Assessment section for details); <input type="checkbox"/> Implantable device(s)/I.V. Access- Location/Date placed: _____ <input type="checkbox"/> Presence of foreign body(ies)/Implants, e.g., metal rod, clip, pin, bullet, pellet, body piercing(s): _____	

Physical Assessment – Check All That Apply																							
Normal Parameters	Variance/Deviations	Patient Problem / Priority Identified																					
<b>Neurological/Cognitive/Perceptual/Psychosocial</b> <input type="checkbox"/> <b>WNL</b>																							
<p>Awake, alert, and oriented to person, place, and time. Follows commands. Clear speech. Bilateral hand grasps equal. Able to verbalize understanding of current state of health. Maintains eye contact. Behavior is appropriate for age and development. Communicates thought processes. No major worries and concerns.</p>	Disoriented to: <input type="checkbox"/> Person; <input type="checkbox"/> Place; <input type="checkbox"/> Time; <input type="checkbox"/> Drowsy; <input type="checkbox"/> Lethargic; <input type="checkbox"/> Forgetful; Speech: <input type="checkbox"/> Slurred* <input type="checkbox"/> Aphasic* LOC (Glasgow Coma Scale)-Circle below: Total: _____	<input type="checkbox"/> High Risk for Injury <input type="checkbox"/> Altered Level of Consciousness <input type="checkbox"/> Altered Thought Process <input type="checkbox"/> Knowledge Deficit <input type="checkbox"/> Memory Deficit <input type="checkbox"/> Sensory Deficit <input type="checkbox"/> Anxiety <input type="checkbox"/> Body Image Disturbance <input type="checkbox"/> Hopelessness <input type="checkbox"/> Powerlessness <input type="checkbox"/> Chronic Low Self-Esteem <input type="checkbox"/> Situational Low Self-Esteem <b>Speech-Language Pathology Referral Initiated:</b> <input type="checkbox"/> ; <b>By Whom:</b> _____																					
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:33%;">Eye Opening Response</th> <th style="width:33%;">Best Verbal Response</th> <th style="width:33%;">Best Motor Response</th> </tr> <tr> <td>Spontaneous = 4</td> <td>Oriented = 5</td> <td>Obeys Commands = 6</td> </tr> <tr> <td>To voice = 3</td> <td>Confused = 4</td> <td>Localizes pain = 5</td> </tr> <tr> <td>To pain = 2</td> <td>Inappropriate Words = 3</td> <td>Withdraws to pain = 4</td> </tr> <tr> <td>None = 1</td> <td>Incomprehensible Sounds = 2</td> <td>Flexion to pain = 3</td> </tr> <tr> <td></td> <td>None = 1</td> <td>Extension to pain = 2</td> </tr> <tr> <td></td> <td></td> <td>None = 1</td> </tr> </table>		Eye Opening Response	Best Verbal Response	Best Motor Response	Spontaneous = 4	Oriented = 5	Obeys Commands = 6	To voice = 3	Confused = 4	Localizes pain = 5	To pain = 2	Inappropriate Words = 3	Withdraws to pain = 4	None = 1	Incomprehensible Sounds = 2	Flexion to pain = 3		None = 1	Extension to pain = 2			None = 1
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	<input type="checkbox"/> Absence of support system; <input type="checkbox"/> Anxious; <input type="checkbox"/> Hostile; <input type="checkbox"/> Flat affect; <input type="checkbox"/> Tearful; <input type="checkbox"/> Depressed; <input type="checkbox"/> Angry; <input type="checkbox"/> Uncooperative; <input type="checkbox"/> Difficulty sleeping; <input type="checkbox"/> Lack of interaction; Describe behavior: _____	
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**Respiratory**  WNL

<b>Lungs:</b> Clear bilaterally. Respirations even, regular, and non-labored. No productive cough, prolonged fever, or night sweats.	<input type="checkbox"/> Dyspneic; <input type="checkbox"/> Tachypneic; <input type="checkbox"/> Orthopneic; Breathing: <input type="checkbox"/> Irregular; <input type="checkbox"/> Shallow; <input type="checkbox"/> Use of accessory muscles; Cough: <input type="checkbox"/> Productive; <input type="checkbox"/> Non-Productive; Secretions: <input type="checkbox"/> Thin; <input type="checkbox"/> Clear; <input type="checkbox"/> Frothy; <input type="checkbox"/> Thick; <input type="checkbox"/> White; <input type="checkbox"/> Yellow; <input type="checkbox"/> Tan; <input type="checkbox"/> Green; <input type="checkbox"/> Blood-tinged; <input type="checkbox"/> O <sub>2</sub> in use: _____	<input type="checkbox"/> Activity Intolerance <input type="checkbox"/> Fatigue <input type="checkbox"/> Impaired Gas Exchange <input type="checkbox"/> Impaired Physical Mobility <input type="checkbox"/> Ineffective Airway Clearance <input type="checkbox"/> Ineffective Breathing Pattern <input type="checkbox"/> Self-Care Deficit																																				
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%;">Auscultated Lungs</th> <th style="width:10%;">RUL</th> <th style="width:10%;">LUL</th> <th style="width:10%;">RML</th> <th style="width:10%;">LLL</th> <th style="width:10%;">RLL</th> </tr> <tr> <td>Clear</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Crackles</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rhonchi</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Wheezes</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Diminished</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Auscultated Lungs	RUL	LUL	RML	LLL	RLL	Clear						Crackles						Rhonchi						Wheezes						Diminished						
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**Cardiovascular**  WNL

<b>Heart:</b> Rhythm regular. No edema. Peripheral pulses 2+ palpable. No calf tenderness. No chest pain or SOA. CTMSP-WNL.	Rhythm: <input type="checkbox"/> Irregular; Skin: <input type="checkbox"/> Cool; <input type="checkbox"/> Cold; <input type="checkbox"/> Pale; <input type="checkbox"/> Cyanotic Pulses: Radial-Right _____; Left- _____ Pedal- Right _____; Left _____	<input type="checkbox"/> Altered Tissue Perfusion <input type="checkbox"/> Decreased Cardiac Output <input type="checkbox"/> Fluid Volume Deficit <input type="checkbox"/> Fluid Volume Excess
	<u>Pulse Scale:</u> D=Doppler. 0=Absent. 1+=Weak, thready. 2+=Normal. 3+=Bounding.	
	Capillary refill: <input type="checkbox"/> within 3 seconds; <input type="checkbox"/> > 3 seconds.	
	Edema: Location(s)/Scale _____	
	<u>Edema Scale:</u> 0=No indentation. 1+=Sl. indentation-quickly disappears. 2+=Mod. indentation-remains 10-15". 3+=Deep indentation-remains 1-2 minutes. 4+=Deep indentation-remains >7 minutes.	

**Musculoskeletal/Activity/Exercise**  WNL

MORSE FALL SCALE	SCORE 0	VARIABLE SCORE (see below)	VARIABLE SCORE (see below)	PATIENT SCORE
History of falling; immediate or within 90 days.	No	Yes (Score 25) *		
Secondary diagnosis, including limited vision or hearing, incontinence, frequency, diuretics, psychotropics, etc.	No	Yes (Score 15)		
Ambulatory Aid	None/bedrest/nurse assist	Crutches/cane/walker (Score 15) *	Furniture (Score 30) *	
Intravenous Therapy/I.V. Lock	No	Yes (Score 20)		
Gait	Normal/bedrest/wheelchair	Weak (Score 10) *	Impaired (Score 20) *	
Mental Status	Oriented to own ability	Overestimates/forgets limitations (Score 15)		
			<b>TOTAL PATIENT SCORE:</b>	*

RISK LEVEL	MORSE FALL SCALE SCORE	INTERVENTION
No Risk	0 – 24	Basic nursing care.
Low Risk	25 – 60	Standard fall prevention indicators.
High Risk	≥ 61	High risk fall prevention indicators.

\* If Morse Fall Scale Score is ≥ 61 or the patient exhibits an of the “\*” items, Physical Therapy Referral Initiated: ; By Whom: \_\_\_\_\_

**Continued from previous page**

<p>Ambulatory. No assistive devices or limitations. Independent with ADLs. Usual ROM to all extremities. Symmetry of strength present. Repositions self. Not a risk for falling.</p>	<p>Extremity weakness: <input type="checkbox"/> RUE; <input type="checkbox"/> LUE  <input type="checkbox"/> RLE; <input type="checkbox"/> LLE  <input type="checkbox"/> Unsteady; <input type="checkbox"/> Paralysis; <input type="checkbox"/> Amputation;  <input type="checkbox"/> Limited ROM. Location: _____          _____</p>	<p><input type="checkbox"/> High Risk for Injury*  <input type="checkbox"/> Noncompliance  <input type="checkbox"/> Altered Protection*  <input type="checkbox"/> Activity Intolerance  <input type="checkbox"/> Impaired Physical Mobility*  <input type="checkbox"/> Fatigue</p> <p><i>*Physical Therapy Referral Initiated:</i><input type="checkbox"/>; <i>By Whom:</i> _____</p>
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**Gastrointestinal(GI)/Nutrition  WNL**

<p>No diet restrictions. Feeds self. No difficulty chewing/swallowing. Abdomen soft and non-distended. Bowels sounds present and normoactive. No nausea/vomiting/diarrhea. BM's as usual. Good appetite. No unintentional weight loss/gain. No cultural or religious food requests. No identified food intolerances.</p>	<p><input type="checkbox"/> Nausea; <input type="checkbox"/> Vomiting; <input type="checkbox"/> Diarrhea; <input type="checkbox"/> Tarry Stools;  <input type="checkbox"/> Incontinent; <input type="checkbox"/> Constipated.  <u>Abdomen:</u> <input type="checkbox"/> Hard; <input type="checkbox"/> Tender; <input type="checkbox"/> Distended;  <u>Bowel Sounds:</u> <input type="checkbox"/> Absent; <input type="checkbox"/> Hypoactive;  <input type="checkbox"/> Hyperactive. Location: _____  <u>Stoma:</u>  <input type="checkbox"/> Dusky; <input type="checkbox"/> Black  <u>Nutrition:</u> <input type="checkbox"/> Special diet: _____  <input type="checkbox"/> Non-compliant with diet;  <input type="checkbox"/> PEG; <input type="checkbox"/> Gastrostomy Tube; <input type="checkbox"/> Jejunostomy Tube.  <input type="checkbox"/> Tube feeding-Type: _____  <input type="checkbox"/> Supplement(s)-Type: _____  <u>Tubes/Drainage:</u>          _____</p>	<p>Altered Nutrition:  <input type="checkbox"/> Less Than Body Requirements*  <input type="checkbox"/> More Than Body Requirements*  <input type="checkbox"/> Fluid Volume Deficit*  <input type="checkbox"/> Fluid Volume Excess*  <input type="checkbox"/> Impaired Skin Integrity*  <input type="checkbox"/> Impaired Swallowing**  <input type="checkbox"/> Potential for Aspiration**  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea</p> <p><i>*Dietitian Referral Initiated:</i><input type="checkbox"/>; <i>By Whom:</i> _____</p> <p><i>**Speech-Language Pathology Referral Initiated:</i><input type="checkbox"/>; <i>By Whom:</i> _____</p>
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**Genitourinary (GU)/Reproductive  WNL**

<p>Urine clear or yellow-amber. Reports ability to empty bladder. No c/o nocturia, dysuria, frequency, urgency, incontinence, hematuria.  <u>Male:</u>          No burning, discharge,. No sexual concerns related to current illness.  <u>Female:</u>          No menstrual or menopausal problems. No burning, discharge. No nipple discharge No sexual concerns related to current illness.</p>	<p><input type="checkbox"/> Nocturia; <input type="checkbox"/> Dysuria/burning; <input type="checkbox"/> Frequency;  <input type="checkbox"/> Urgency; <input type="checkbox"/> Incontinence; <input type="checkbox"/> Hematuria;  <input type="checkbox"/> Dribbling; <input type="checkbox"/> Bladder distended; <input type="checkbox"/> Bladder spasms;  <input type="checkbox"/> Stress incontinence.  <u>Urine color:</u> <input type="checkbox"/> Cloudy; <input type="checkbox"/> Concentrated; <input type="checkbox"/> Sediment  <u>Tubes/Drainage:</u>          Foley: # _____ Fr; Date placed: _____          _____  <input type="checkbox"/> <u>Other-Describe:</u> _____          _____</p>	<p><input type="checkbox"/> Incontinence  <input type="checkbox"/> Stress Incontinence  <input type="checkbox"/> Urinary Retention</p>
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**Integumentary  WNL**

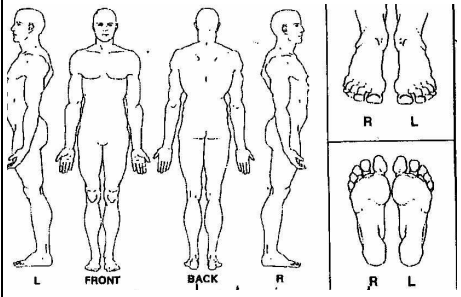
BRADEN PRESSURE ULCER RISK ASSESSMENT SCALE	SCORE 1	SCORE 2	SCORE 3	SCORE 4	PATIENT SCORE
<b>Sensory Perception</b>	Completely Limited	Very Limited	Slightly Limited	No Impairment	
<b>Moisture</b>	Constantly Moist	Very Moist	Occasionally Moist	Rarely Moist	
<b>Activity</b>	Bedfast	Chairfast	Walks Occasionally	Walks Frequently	
<b>Mobility</b>	Completely Mobile	Very Limited	Slightly Limited	No Limitations	
<b>Nutrition</b>	Very Poor	Probably Inadequate	Adequate	Excellent	
<b>Friction and Shear</b>	Problem	Potential Problem	No Apparent Problem		
<b>Risk Assessment:</b> Low Risk = 15-18; Moderate Risk=13-14; High Risk = ≤12				<b>TOTAL PATIENT SCORE:</b>	*

\* If Braden Pressure Ulcer Risk Assessment Scale is ≤ 14, Dietitian Referral Initiated:; By Whom: \_\_\_\_\_

Continued from previous page

**Identify anatomical locations of altered skin integrity.**

**Place “#” to designate location sequentially.**

	<u>Site #:</u>	<u>Picture Taken:</u>	<u>Description:</u>
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

See Skin Integrity Assessment to document any alterations in skin integrity.

Skin intact, warm, and dry. Color WNL. Turgor elastic. Mucous membranes pink, moist, and free of lesions. No rashes.	<b>Color</b>	<b>Condition</b>	<b>Turgor</b>	<b>Temperature</b>	<input type="checkbox"/> Impaired Skin Integrity <input type="checkbox"/> High Risk for Infection
	<input type="checkbox"/> Pale	<input type="checkbox"/> Rash	<input type="checkbox"/> Poor	<input type="checkbox"/> Hot	
	<input type="checkbox"/> Mottled	<input type="checkbox"/> Lesions	<input type="checkbox"/> Dry	<input type="checkbox"/> Cool	
	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Ecchymosis		<input type="checkbox"/> Cold	
	<input type="checkbox"/> Jaundiced				

**Pain Assessment**  WNL

No pain reported.	Patient’s description of: Location: _____ Quality: <input type="checkbox"/> Sharp; <input type="checkbox"/> Dull; <input type="checkbox"/> Aching; <input type="checkbox"/> Constant; <input type="checkbox"/> Intermittent; <input type="checkbox"/> Pressure; <input type="checkbox"/> Tightness; <input type="checkbox"/> Squeezing <input type="checkbox"/> Heavy Intensity (score 0-10): _____ How long have you been in pain? _____ What makes it better? _____ What makes it worse? _____	<input type="checkbox"/> Pain <input type="checkbox"/> Chronic Pain
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**Discharge Planning**

<input type="checkbox"/> Independent: May return home with education on medical plan; no additional resources needed. <input type="checkbox"/> Interdependent: May return to community with additional resources/services. <i>Social Work Referral Initiated:</i> <input type="checkbox"/> ; <i>By Whom:</i> _____ <input type="checkbox"/> Dependent: Will return to or need placement in another facility. <i>Social Work Referral Initiated:</i> <input type="checkbox"/> ; <i>By Whom:</i> _____	<input type="checkbox"/> Discharge Planning <input type="checkbox"/> Ineffective Coping: Family-S/O <input type="checkbox"/> Ineffective Coping: Individual <input type="checkbox"/> Caregiver Role Strain <input type="checkbox"/> High Risk for Violence <input type="checkbox"/> Parental Role Conflict
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Signature of LPN: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ hours

Signature of RN: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ hours