MURRAY-CALLOWAY COUNTY HOSPITAL
Taking healthcare new places.

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_2: _____; 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

☐ Glasses; ☐ Contact Lenses	☐ Family / Significant Other/Caregiver; ☐ Patient
☐ Dentures; ☐ Upper; ☐ Lower	☐ Family / Significant Other/Caregiver; ☐ Patient
☐ Hearing Aid	☐ Family / Significant Other/Caregiver; ☐ Patient
☐ Cane / Crutches / Walker / Wheelchair	☐ Family / Significant Other/Caregiver; ☐ Patient
☐ Prosthesis (es); ☐ Brace(s)	☐ Family / Significant Other/Caregiver; ☐ Patient
☐ Equipment:	☐ Family / Significant Other/Caregiver; ☐ Patient
☐ Valuables	☐ Family / Significant Other/Caregiver; ☐ Patient; ☐ Security
☐ Medications	☐ Family / Significant Other/Caregiver; ☐ 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 ☐ Iodine; ☐ Shellfish; ☐ Latex			
☐ Allergy; ☐ ADR:			
☐ Allergy; ☐ ADR:			
☐ Allergy; ☐ ADR:			
☐ Allergy; ☐ 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? _____

Previous Hospitalizations / Surgeries ☐ None	
Date(s)	**Diagnosis / Type**

Home Medications
☐ None; ☐ List unavailable physician contacted.

Medication list is provided by: ☐ Patient; ☐ Family; ☐ Significant Other/Caregiver; ☐ Physician; ☐ Other facility:_____

Medication	Dose	Route	Frequency	Last Dose Taken	Comments
Prescription					
Over The Counter (OTC)					
Herbals / Vitamins / Supplements					

Health History – Check All That Apply

Neurological/Mental Health ☐ No Relevant History

☐ Headache/Migraine; ☐ Syncope; ☐ Seizures; ☐ Epilepsy;
☐ TIA; ☐ CVA; ☐ Cancer; Paralysis: ☐ R ☐ L; ☐ Neuropathy;
☐ Other: _____
☐ Anxiety; ☐ Depression; ☐ Suicidal Attempt; ☐ Overdose;
☐ Psychiatric Illness; Details:_____

Cognitive/Perceptual ☐ No Relevant History

Vision: ☐ Glaucoma; ☐ Blind; Cataracts: ☐ R ☐ L;
☐ Visual Aids: ☐ With Patient ☐ Not With Patient
Hearing: ☐ Deaf; ☐ ↓Hearing: ☐ R ☐ L
☐ Hearing Aids: ☐ With Patient ☐ Not With Patient
☐ Other:

Psychosocial ☐ No Relevant History

Do you use :
☐ Alcohol: Type/Amount: _____
☐ Recreational drugs: Type/Amount: _____
☐ Lives alone; ☐ Will require assistance post discharge;
☐ Assistance required at home: Whom: _____
☐ Home Health; ☐ Adult Day Care; ☐ Hospice;
☐ Resident of LTC facility: Where: _____
Social Work Referral Initiated:☐; By Whom:_____

Domestic Violence/Cultural Diversity ☐ No Relevant History

Because so many people deal with fear and abuse in their relationships, we ask all patients:
"Are you being hurt, hit or frightened by anyone at home or in your life?" ☐ No; ☐ Yes
Social Work Referral Initiated:☐; By Whom:_____
"Do you have any special religious, spiritual or cultural needs to be considered?" ☐ No; ☐ Yes
Pastoral Care Referral Initiated:☐; By W hom:_____

Respiratory ☐ **No Relevant History**

☐ Chronic cough; ☐ Asthma; ☐ TB; ☐ Emphysema; ☐ COPD;
☐ Pneumonia; ☐ Pulmonary Embolus; ☐ Cancer;
☐ Sleep Apnea:
Device/Settings: _____/_____;
☐ O_2 @ home: Liters/minute: _____;
Smoker: ☐ History; ☐ Present; ☐ Cigarettes: Packs Per Day: ____;
☐ Cigars; ☐ Chewing Tobacco; ☐ Snuff
# of years of tobacco use: _____
Smoking Cessation Referral Initiated: ☐ ***; By Whom:_____***

Immunological ☐ **No Relevant History**

Influenza vaccine within past year: ☐ Yes-Date:_____
☐ No-Between October and February only and if patient is > 50 y/o or has chronic illness:
Physician Referral Initiated: ☐ ***; By Whom:_____***
Pneumococcal vaccine within last 5 years: ☐ Yes-Date: _____
☐ No-If patient is > 65 y/o or has chronic illness:
Physician Referral Initiated: ☐ ***; By Whom:_____***
Last Tuberculin Skin Test? ☐ Unknown: ☐ Date:_____
Results: ☐ Negative; ☐ Positive.
History of HIV: ☐ AIDS: ☐ Other:_____
Cancer Treatment: ☐ Chemotherapy; ☐ Radiation

Cardiovascular ☐ **No Relevant History**

☐ Angina; ☐ MI; ☐ Hypertension; ☐ CHF; ☐ A-Fib;
☐ Pacemaker; ☐ Implantable Defibrillator; ☐ Angioplasty;
☐ Stents; ☐ CABG; ☐ Mitral Valve Prolapse; ☐ Palpitations;
☐ Heart Murmur; ☐ Other:_____

Musculoskeletal ☐ **No Relevant History**

☐ Arthritis; ☐ Osteoporosis; ☐ Chronic pain;
☐ Fracture(s):_____; ☐ Joint Replacement: _____
☐ Foreign body(ies): _____
Use(s): ☐ Walker; ☐ Wheelchair; ☐ Cane; ☐ Other:

Gastrointestinal(GI)/Metabolic/Nutrition ☐ **No Relevant History**

☐ GI Ulcer; ☐ GI Bleeding; ☐ Diarrhea; ☐ Constipation;
☐ GERD; ☐ IBS/Crohn's*****; ☐ Diverticulitis; ☐ Hepatitis A, B, C
☐ Anemia; ☐ Liver Disease; ☐ Cancer; ☐ Hiatal Hernia;
☐ Hemorrhoids; ☐ Uses laxatives; ☐ Unintentional weight loss/ Malnourished***** ☐ On tube feeding or TPN or PPN*****
☐ Inadequate intake***** ☐ Loss of appetite x 1 week***** ☐ Pregnant and/or Lactating***** ☐ Eating Disorder***** ☐ Other:_____
_____*****
If yes to any items with an * initiate a Dietitian referral:
Dietitian Referral Initiated: ☐ ***; By Whom:_____***
_____

☐ Diabetes- Type:_____; ☐ Insulin Pump***** ☐ Anemia;
☐ New diagnosis***** ☐ Has not received OP education in the last year*****
☐ Diagnosis of uncontrolled DM, DKA, HHNK, Hyperglycemia*****
☐ HgbA1C > 7%***** ☐ Polyuria***** ☐ Polydipsia***** ☐ Patient request*****
Other: _____*****
If yes to any items with an * initiate a Center for Diabetes referral:
Center for Diabetes Referral Initiated: ☐ ***; By Whom:_____***
☐ Clotting Disorder; ☐ Thyroid Problem; ☐ Cancer;
☐ Blood Transfusion History; Reaction: ☐ No ☐ Yes-Type:
_____

Genitourinary (GU)/Reproductive ☐ **No Relevant History**

☐ Incontinence; ☐ Kidney Stones; ☐ UTI; ☐ Renal Failure; ☐ Retention; ☐ Cancer-Type: _____
☐ Dialysis-Date of last treatment: _____
☐ STD-Type: _____
Female:
☐ Reproductive problems:_____
☐ Performs Self Breast Exams;
Last Pap:_____; Last Mammogram:_____
Date of LMP:_____; ☐ Pregnant; ☐ Lactating;
Male:
Last Prostate Screening Exam:_____
Last Testicular Exam:_____
☐ Performs Self Testicular Exams;
☐ BPH; ☐ Enlarged Prostate; ☐ Reproductive problems:
_____

Integumentary ☐ **No Relevant History**

☐ History of skin breakdown (see Physical Assessment section for details); ☐ Implantable device(s)/I.V. Access-Location/Date placed: _____
☐ 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
Neurological/Cognitive/Perceptual/Psychosocial ☐ **WNL**				
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.	Disoriented to: ☐ Person; ☐ Place; ☐ Time; ☐ Drowsy; ☐ Lethargic; ☐ Forgetful; Speech: ☐ Slurred***** ☐ Aphasic***** LOC (Glasgow Coma Scale)-Circle below: Total: ____			☐ High Risk for Injury ☐ Altered Level of Consciousness ☐ Altered Thought Process ☐ Knowledge Deficit ☐ Memory Deficit ☐ Sensory Deficit ☐ Anxiety ☐ Body Image Disturbance ☐ Hopelessness ☐ Powerlessness ☐ Chronic Low Self-Esteem ☐ Situational Low Self-Esteem ***Speech-Language Pathology Referral Initiated:*** ☐ ***; By Whom:_____***
	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	Incomprehensive Sounds = 2	Flexion to pain = 3	
		None = 1	Extension to pain = 2	
			None = 1	

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	☐ Absence of support system; ☐ Anxious; ☐ Hostile; ☐ Flat affect; ☐ Tearful; ☐ Depressed; ☐ Angry; ☐ Uncooperative; ☐ Difficulty sleeping; ☐ Lack of interaction; Describe behavior:_____ _____	

Respiratory ☐ WNL

Lungs: Clear bilaterally. Respirations even, regular, and non-labored. No productive cough, prolonged fever, or night sweats.	☐ Dyspneic; ☐ Tachypneic; ☐ Orthopneic; Breathing: ☐ Irregular; ☐ Shallow; ☐ Use of accessory muscles; Cough: ☐ Productive; ☐ Non-Productive; Secretions: ☐ Thin; ☐ Clear; ☐ Frothy; ☐ Thick; ☐ White; ☐ Yellow; ☐ Tan; ☐ Green; ☐ Blood –tinged; ☐ O_2 in use: _____	☐ Activity Intolerance ☐ Fatigue ☐ Impaired Gas Exchange ☐ Impaired Physical Mobility ☐ Ineffective Airway Clearance ☐ Ineffective Breathing Pattern ☐ Self-Care Deficit

Auscultated Lungs	RUL	LUL	RML	LLL	RLL
Clear					
Crackles					
Rhonchi					
Wheezes					
Diminished					

Cardiovascular ☐ WNL

Heart: Rhythm regular. No edema. Peripheral pulses 2+ palpable. No calf tenderness. No chest pain or SOA. CTMSP-WNL.	Rhythm: ☐ Irregular; Skin: ☐ Cool; ☐ Cold; ☐ Pale; ☐ Cyanotic Pulses: Radial-Right_____; Left-_____ Pedal- Right_____; Left_____	☐ Altered Tissue Perfusion ☐ Decreased Cardiac Output ☐ Fluid Volume Deficit ☐ Fluid Volume Excess
	Pulse Scale: D=Doppler. 0=Absent. 1+=Weak, thready. 2+=Normal. 3+=Bounding.	
	Capillary refill: ☐ within 3 seconds; ☐ > 3 seconds. Edema: Location(s)/Scale_____ Edema Scale: 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)		
			TOTAL PATIENT SCORE:	*

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:_____***

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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.	Extremity weakness: ☐ RUE; ☐ LUE ☐ RLE; ☐ LLE ☐ Unsteady; ☐ Paralysis; ☐ Amputation; ☐ Limited ROM. Location: _____ _____	☐ High Risk for Injury* ☐ Noncompliance ☐ Altered Protection* ☐ Activity Intolerance ☐ Impaired Physical Mobility* ☐ Fatigue ***Physical Therapy Referral Initiated:☐; By Whom:_____***
Gastrointestinal(GI)/Nutrition ☐ WNL		
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.	☐ Nausea; ☐ Vomiting; ☐ Diarrhea; ☐ Tarry Stools; ☐ Incontinent; ☐ Constipated. Abdomen: ☐ Hard; ☐ Tender; ☐ Distended; Bowel Sounds: ☐ Absent; ☐ Hypoactive; ☐ Hyperactive. Location:_____ Stoma: ☐ Dusky; ☐ Black Nutrition: ☐ Special diet:_____ ☐ Non-compliant with diet; ☐ PEG; ☐ Gastrostomy Tube; ☐ Jejunostomy Tube. ☐ Tube feeding-Type:_____ ☐ Supplement(s)-Type:_____ Tubes/Drainage: _____ _____	Altered Nutrition: ☐ Less Than Body Requirements* ☐ More Than Body Requirements* ☐ Fluid Volume Deficit* ☐ Fluid Volume Excess* ☐ Impaired Skin Integrity* ☐ Impaired Swallowing** ☐ Potential for Aspiration** ☐ Constipation ☐ Diarrhea ***Dietitian Referral Initiated:☐; By Whom:_____*** ****Speech-Language Pathology Referral Initiated:☐; By Whom:_____***
Genitourinary (GU)/Reproductive ☐ WNL		
Urine clear or yellow-amber. Reports ability to empty bladder. No c/o nocturia, dysuria, frequency, urgency, incontinence, hematuria. Male: No burning, discharge,. No sexual concerns related to current illness. Female: No menstrual or menopausal problems. No burning, discharge. No nipple discharge No sexual concerns related to current illness.	☐ Nocturia; ☐ Dysuria/burning; ☐ Frequency; ☐ Urgency; ☐ Incontinence; ☐ Hematuria; ☐ Dribbling; ☐ Bladder distended; ☐ Bladder spasms; ☐ Stress incontinence. Urine color: ☐ Cloudy; ☐ Concentrated; ☐ Sediment Tubes/Drainage: Foley: #_____Fr; Date placed: _____ _____ _____ ☐ Other-Describe:_____ _____	☐ Incontinence ☐ Stress Incontinence ☐ Urinary Retention

Integumentary ☐ WNL

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

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

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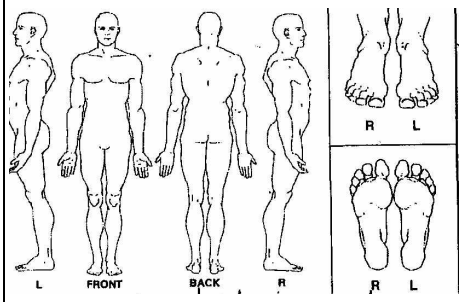
Identify anatomical locations of altered skin integrity.
Place "#" to designate location sequentially.



Site #:	Picture Taken:	Description:
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____
_____		_____

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.	**Color**	**Condition**	**Turgor**	**Temperature**	☐ Impaired Skin Integrity ☐ High Risk for Infection
	☐ Pale	☐ Rash	☐ Poor	☐ Hot	
	☐ Mottled	☐ Lesions	☐ Dry	☐ Cool	
	☐ Cyanotic	☐ Ecchymosis		☐ Cold	
	☐ Jaundiced				

Pain Assessment ☐ WNL

No pain reported.	Patient's description of: Location:_____ Quality: ☐ Sharp; ☐ Dull; ☐ Aching; ☐ Constant; ☐ Intermittent; ☐ Pressure; ☐ Tightness; ☐ Squeezing ☐ Heavy Intensity (score 0-10): _____ How long have you been in pain?_____ What makes it better?_____ What makes it worse?_____	☐ Pain ☐ Chronic Pain

Discharge Planning

☐ Independent: May return home with education on medical plan; no additional resources needed. ☐ Interdependent: May return to community with additional resources/services. ***Social Work Referral Initiated:☐; By Whom:_____*** ☐ Dependent: Will return to or need placement in another facility. ***Social Work Referral Initiated:☐; By Whom:_____***	☐ Discharge Planning ☐ Ineffective Coping: Family-S/O ☐ Ineffective Coping: Individual ☐ Caregiver Role Strain ☐ High Risk for Violence ☐ Parental Role Conflict

Signature of LPN:_____ Date:_____ Time:_____ hours

Signature of RN:_____ Date:_____ Time:_____ hours