



MR# \_\_\_\_\_  
 LW Acct# \_\_\_\_\_  
 Name \_\_\_\_\_

# Admission History

*Complete or Imprint with Address-O-Plate*

**Admission Data**

Date \_\_\_\_\_ Time \_\_\_\_\_

T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

BP \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

**Orientation to Room/Unit**

Light/Emerg Call     Patient Handbook  
 Bed Controls/Siderails     Safety  
 Visiting Hours     TV/Pt Ed Channels  
 Inability to Understand Instructions  
 Explained to:  Family     Patient

Are you currently using any mode of alternative therapy?     Yes     No  
 (specify) \_\_\_\_\_

ID Bracelet ON Patient

**Health History** (see review of systems on back)

Information Source  
 Patient     Other (name/relationship): \_\_\_\_\_

**Spiritual/Cultural/Social Information**

Are there any religious traditions, ethnic practices or cultural practices that need to be part of your care?  
 No     Yes (explain): \_\_\_\_\_

**Allergies**     Allergy Bracelet On

No Known Allergies     Medication    Reaction

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Food \_\_\_\_\_  
 Latex \_\_\_\_\_     IV Contrast (Dye)/Iodine  
 Uncertain  
 Other \_\_\_\_\_

Stated Reason for Hospitalization \_\_\_\_\_

Unable to Obtain Hx at Present Reason: \_\_\_\_\_

History of falls at home/prior hospitalizations

Chemotherapy     Radiation Therapy

Transplant (type) \_\_\_\_\_

Cancer (type) \_\_\_\_\_

Past Surgeries \_\_\_\_\_

\_\_\_\_\_

Isolation Care Precautions Other than Universal Type \_\_\_\_\_

Other Pertinent Info \_\_\_\_\_

Unable to Obtain Social/Discharge info due to: \_\_\_\_\_

Lives:  Alone     Spouse     Children  
 Parents     Other (specify) \_\_\_\_\_

Smokes  
 How Long? \_\_\_\_\_ Packs/Day \_\_\_\_\_  
 Informed of Hospital Smoking Policy  
 Interested in Smoking Cessation Education

Alcohol  
 How Long? \_\_\_\_\_ Amount? \_\_\_\_\_  
 Last Drink (time/amount) \_\_\_\_\_

Recreational Drugs (type/amount/last used) \_\_\_\_\_

Contact/Support Person Present :  Yes     No  
 Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

**Advance Directives**

1. Does the patient have an advance Directive  
 Yes     No

Is the advance Directive on the Chart?  
 Yes     No

If No (check all that apply):  
 Patient/Family encouraged to bring in the advance directive  
 RN will discuss with physician: essence of advance directive will be documented in progress notes by physician  
 Patient asked whether he/she wants to develop a new advance directive

2. If the patient does not have an advance directive, was the information given to the patient?  
 Yes     No

If No:  
 Patient unable to review advance directive information because of confusion or unresponsiveness  
 Patient Declined Information

3. Does patient wish assistance in developing an advance directive?  
 Yes     No

If Yes, was Social Work Notified?  
 Yes     No

**Medications**     None

Current medications being taken: (include over-the-counter medications, herbals, and non-traditional medications)

Name/Dose/Frequency	Last Taken
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Valuable/Personal Property**

**Prosthetic Devices**     None

	With Pt: Yes	No
<input type="checkbox"/> Dentures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Glasses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hearing Aid (R/L)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Limb Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Glass Eye	<input type="checkbox"/>	<input type="checkbox"/>

**Assistive Devices**     None

	With Pt: Yes	No
<input type="checkbox"/> Walker	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Braces	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cane	<input type="checkbox"/>	<input type="checkbox"/>

**Valuable/Personal Items/Medications**

Item	Home	W/Pt	Secured
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sent Home with (relationship) _____			

Secured Location \_\_\_\_\_

Non-RN Signature \_\_\_\_\_ Unit \_\_\_\_\_ Date/Time \_\_\_\_\_

IMPORTANT: DO NOT WRITE IN MARGINS

# Admission History

Patient Name \_\_\_\_\_

MR# \_\_\_\_\_

## Social Work/Case Management Screen

Enter consult in Last Word or call SW Consult line at 5-7172 if any condition is present.

- Trauma or New SCI
- Difficulty Coping with Diagnosis/Traumatic Incident
- Mental Health Impairment (eating disorder/suicide)
- Unknown Identity/Unknown Next of Kin
- No Parent on Admission for a Minor Under 18
- Boarding Home/Nursing Home Return
- Unable to Return Home
- Financial Difficulties (lack of gas, electric, water, medication coverage, etc.)
- Lack of Transportation for Discharge
- Assistance with Advance Directive
- Abuse/Neglect (child/older adult/domestic violence)
- Drug/Alcohol/Substance Abuse
- Positive Drug Screen of Newborn/Parent of Newborn/Child
- No Prenatal Care
- Pregnant Woman Under 16
- Fetal Demise
- Adoption/Foster Care Placement
- Other Concerns that would Impede Discharge
- Other Concerns Impeding Psychosocial Functioning (non-compliance, end of life issues)
- Other \_\_\_\_\_
- No Conditions Identified**

## Screening Criteria for Nutrition

Enter consult in Last Word or contact Department of Nutrition and Dietetics at ext. 5-7144 if any condition is present.

- Food Allergy
- Unintentional Weight Loss > 15lbs in past 3 months
- On Tube Feeding or anticipate Tube Feeding
- On TPN or PN or anticipate TPN or PN
- Stage 2 or greater Decubitus Ulcer or Non-healing Wound
- Jaw/Mandibular Fx/Wired Jaw
- Anorexia Nervosa or Bulimia
- Difficulty swallowing or other problems that prevent eating
- Other \_\_\_\_\_
- No Conditions Identified**

## Geriatric Surgical and Adult Surgical Patients (above criteria plus the following)

- Esophagectomy
- Enterocutaneous Fistula Repair
- Radical Neck Surgery
- Whipple Procedure
- Other \_\_\_\_\_
- No Conditions Identified**

## Pregnant Woman

- Gestational Diabetic
- Hyperemesis
- Lactating (assessment by RN/Lactation specialist at Center City)
- Other \_\_\_\_\_
- No Conditions Identified**

(Call pharmacy at 5-7147 if pregnant or lactating)

## Rehab Screen

Enter consult in Last Word or contact PT/OT at 5-7445 (physician order needed) for new onset of deficits in:

### Occupational Therapy

- Bathing/Toileting  Dressing/Grooming
- Feeding  Toileting
- Strength, Balance, Coordination, Range of Motion  Home Management
- Judgement/Safety  Vision
- Cognition and Perception
- Other \_\_\_\_\_
- No Conditions Identified**

### Physical Therapy

- Strength, Balance, Coordination, Range of Motion  Transfers
- Stairs  Bed Mobility
- Wheel Chair Mobility  Ambulation
- Other \_\_\_\_\_
- No Conditions Identified**

## Rehab Screen (continued)

### Speech Language Pathology

Contact Speech Services at 5-2554

- Communication  Speech/Language
- Swallowing
- Other \_\_\_\_\_
- No Conditions Identified**

### EENT

- No Hx/Conditions Identified**
- Glaucoma/ Cataracts  Sinus Problems
- Loose Teeth  Difficulty Hearing  TMJ
- Airway Device  Hoarseness  Mouth Sores
- Dental Problems  Stiff Neck
- Bleeding Gums  Epistaxis

Hearing Deficit  Right  Left

Vision Deficit  Right  Left

Comments: \_\_\_\_\_

### Resp

- No Hx/Conditions Identified**
- Tuberculosis  Asthma
- Pneumonia  COPD
- Emphysema  Home O<sub>2</sub>
- Cough  Productive  Non-Productive
- Dyspnea  At Rest  With Exertion
- Sleep Apnea (at home use of):  BiPap  CPAP

Comments: \_\_\_\_\_

### Cardiac

- No Hx/Conditions Identified**
- High Blood Pressure
- Irregular Heartbeat
- Palpitations
- Murmur
- Chest Pain/Angina
- Heart Attack
- Phlebitis/Varicose Veins
- Bleeding Disorder
- Angioplasty/Stents
- Pacemaker
- Implanted Defibrillator/AICD
- Vascular Access Device

Comments: \_\_\_\_\_

### GI

- No Hx/Conditions Identified**
- Nausea  Vomiting
- Diarrhea  Ulcers
- Blood in Stool  Constipation
- Liver Disease  Jaundice
- Gallbladder Prob.  Hepatitis
- Inflammatory  Pancreatitis
- Bowel Disease
- Hiatal Hernia/Heartburn/Acid Reflux
- Incontinence  GI Diversion
- Weight  Recent Gain  Recent Loss

Last BM \_\_\_\_\_

Comments: \_\_\_\_\_

### GU/Repro

- No Hx/Conditions Identified**
- Kidney Disease  Kidney Stones
- Blood in Urine  Difficulty Urinating
- Prostate Problems  Urgency
- Hesitancy  Incontinence
- Dribbling  Nocturia
- Frequency  Nocturia
- Urinary Diversion \_\_\_\_\_
- Dialysis Access Location \_\_\_\_\_
- Vaginal/Penile Discharge
- Breast Problems  Hysterectomy
- Vaginal Bleeding
- LMP \_\_\_\_\_
- Pregnant ( \_\_\_\_\_ weeks)

Comments: \_\_\_\_\_

## Neuromuscular

- No Hx/Conditions Identified**
- Back Pain  Arthritis/Gout
- Joint Pain/Swelling
- Amputation \_\_\_\_\_
- Contracture \_\_\_\_\_
- Fractures \_\_\_\_\_
- Unsteady Gait
- Requires Assistance to Ambulate
- Limited ROM
- Unable to Bear Weight (RLE/LLE)
- Blurred Vision  Migraines
- Headaches  Seizures
- Dizziness  Stroke
- Numbness/Tingling
- Paralysis: location \_\_\_\_\_
- Inappropriate Behavior
- Slurred Speech
- Aphasia
- Dysphagia
- Muscle  Weakness  Flaccid  Spastic
- Location \_\_\_\_\_

Comments: \_\_\_\_\_

## Endocrine

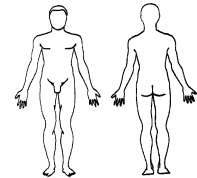
- No Hx/Conditions Identified**
- Thyroid Disease/Goiter
- Heat or Cold Intolerance
- Long Term Steroids
- Diabetes Type 1  Fever
- Diabetes Type 2  Night Sweats
- Diabetes Other \_\_\_\_\_

Comments: \_\_\_\_\_

## Comfort No Hx/Conditions Identified

Patient Goal \_\_\_\_\_

Where is Pain Now?



Describe the pain \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_

What relieves the pain? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

List pain meds \_\_\_\_\_

Are they effective? \_\_\_\_\_

Does pain interfere with daily activities? \_\_\_\_\_

With sleep? \_\_\_\_\_

Which number best describes your pain? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

## Psych

- No Hx/Conditions Identified**
- Alcohol/Drug Abuse
- Other Addictions
- Psychiatric Disorder
- Suicidal Ideations
- Grieving
- Chronic Anxiety
- Depressed Affect
- Hallucinations

Comments: \_\_\_\_\_

## Skin

- No Hx/Conditions Identified**
- Skin Problems
- Rashes
- Pressure Ulcers
- Infection: site \_\_\_\_\_

Comments: \_\_\_\_\_

IMPORTANT: DO NOT WRITE IN MARGINS

RN Signature \_\_\_\_\_

Unit \_\_\_\_\_

Date/Time \_\_\_\_\_

Updated By \_\_\_\_\_

Unit \_\_\_\_\_

Date/Time \_\_\_\_\_