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ADMISSION DATABASE

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DEMOGRAPHICS

Date of Admission: _____ Room Number: _____
Time of Arrival: _____
Arrived From: Hospital ☐ _____
Nursing Home ☐ _____
Direct Admit ☐
Mode of Arrival: Ambulance ☐ Ambulatory ☐
Stretcher ☐ Wheelchair ☐
Private Vehicle ☐
Accompanied by: _____ Relationship: _____
Primary MD: _____
Notification Date: _____ Time: _____

ID band placed: Yes ☐ No ☐
Allergy Band Placed: Yes ☐ No ☐
Allergies/Reaction: _____

Isolation Status: _____ Reason _____
Vital Signs: Temp _____ Resp _____
Pulse _____ BP _____
Height: _____ ft., in. Actual ☐ Stated ☐
Weight: _____ lbs. Actual ☐ Stated ☐
Orient to Room: Call Light ☐
Bed Operation ☐ Bathroom ☐
Side Rails ☐ Personal Items ☐
Telephone ☐ Meals ☐
Television ☐ Isolation ☐
Patient information Booklet Provided ☐ Smoking Policy ☐
Chief complaint (patient's own words) _____

CODE Status: Full ☐ DNR ☐ Other: _____
Patient Medical History:

Heart Disease	☐	ESRD/Renal Disease	☐
Hypertension	☐	Peripheral Vascular Disease	☐
Diabetes	☐	Arthritis/Joint Disease	☐
Stroke	☐	Fainting/Dizziness	☐
COPD/Emphysema	☐	Alzheimers/Dementia	☐
Hepatitis/Liver Disease	☐	TB/Flu/Pneumonia	☐

Other Medical History / Past Surgeries: _____

Current Smoker ☐ Hx of smoking: _____ yrs
Non-smoker ☐

Any prior exposure to TB?	Yes ☐	No ☐
Any symptoms of cough > 3 weeks?	Yes ☐	No ☐
Fever	Yes ☐	No ☐
Night Sweats	Yes ☐	No ☐
Hemoptysis	Yes ☐	No ☐
Weight loss	Yes ☐	No ☐
Anorexia	Yes ☐	No ☐

Vaccinations: Influenza ☐ Date: _____
Pneumonia ☐ Date: _____
Other: _____ ☐ Date: _____

MEDICATIONS

Information obtained from:
Nursing Home MAR ☐ Patient/Family ☐
Hospital MAR ☐ (Direct Admit)
MAR Available ☐
Are you taking any herbal supplements? Yes ☐ No ☐
If no MAR available, list all meds and herbal supplement below:

Name	Dose	Frequency	Last Taken

VALUABLES / BELONGINGS

Patient Valuables:
None ☐
Policy Explained ☐
Keep in Room ☐
Hospital Safe ☐ Envelope No.: _____
Sent Home ☐ With: _____

Items Kept in Room:

Clothes	☐	Walker/Cane/Crutches	☐
Money	☐	Wheelchair	☐
Purse/Wallet	☐	Glasses/Hearing Aid	☐
Watch/Bracelet	☐	Dentures - Upper	☐
Necklace	☐	Lower	☐
Earrings/Ring	☐	Partial	☐

Other _____

FUNCTIONAL STATUS

Highest Level of Function: Upon admission

Level legend:		
	Walking	☐
	Transferring	☐
(5) Self	Toileting	☐
(4) Supervised	Bathing	☐
(3) Min Assist	Dressing	☐
(2) Mod Assist	Grooming	☐
(1) Max Assist	Eating	☐

Since hospitalization:
Have you been able to get out of bed? Yes ☐ No ☐
- If so, did you get dizzy? Yes ☐ No ☐
Have you been able to sit up? Yes ☐ No ☐
- If so, how long did you sit up? _____ minutes/hours

Only fill out if precautions for Weight Bearing on lower extremities.
Weight Bearing Status: Full weight Bearing ☐
Partial Weight Bearing R / L ☐
Weight Bearing as Tolerated R / L ☐
Touch Down Weight Bearing R / L ☐
Non-weight Bearing R / L ☐

Completed by: _____ Date: _____ Time: _____

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ADMISSION DATABASE
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PATIENT LABEL

PSYCHOSOCIAL ASSESSMENT

Able to communicate effectively Yes ☐ No ☐
Any history of mental illness or currently on antidepressants, etc.?

Coping skills regarding health/illness:
- Coping skills effective ☐
- Coping skills ineffective ☐
- Able to adapt to changes ☐
- Difficulty adapting to changes ☐

Support system:
- Spouse/significant other ☐
- Family ☐
- Friends ☐
- Other ☐
- None ☐

Do you have any particular religious/cultural practices? _____

Are there any physical signs of abuse/neglect? Yes ☐ No ☐

If so, notify case management Date: _____ Time: _____

BRADEN SCALE

		Score
Sensory Perception	1: Completely Limited, unresponsive 2: Very limited, responds to pain only 3: Slightly limited, responds to voice 4: No impairment, no sensory deficit	☐
Moisture	1: Constantly moist, frequent linen changes 2: Usually moist, +2 linen changes/shift 3: Occasionally moist, +2 linen changes/day 4: Rarely moist, daily linen changes	☐
Activity	1: Bed-rest or confined to bed 2: Chair only, and needs assist to/from chair 3: Slightly limited, minimally dependent 4: No limitations, completely independent	☐
Mobility	1: Completely immobile, totally dependent 2: Very limited, mostly dependent 3: Slightly limited, minimally dependent 4: No limitations, completely independent	☐
Nutrition	1: Very poor intake/NPO + 5 days 2: Probably inadequate, eats < 50% meals 3: Adequate, eats > 50%, TPN, tube feeding 4: Excellent, eats > 75% all meals, snacks	☐
Friction & Shear	1: Problem, mod/max assist in moving 2: Potential problem, min assist in moving 3: No apparent problem, moves w/o assist	☐

Total Score _____

Based on the Braden Scale Score, initiate the appropriate Protocol
Results: > 14 – NOT AT RISK - Conservative Pressure Ulcer Prevention
? 13 – AT RISK - Strict Pressure Ulcer Prevention

NUTRITION SCREEN

Please check all that may apply:
- Difficulty chewing (due to dementia) ☐
- Swallowing /aspiration precautions ☐
- Poor intake/inability to take food or fluid >3 days ☐
- Tube feeding or TPN/PPN ☐
- Requires assistance with feeding ☐
- Nausea/vomiting/diarrhea/constipation >3 days ☐
- Albumin <2.8 g/dl or prealbumin <16 mg/dl ☐
- Significant unintentional weight loss ☐
- Skin breakdown/wounds ☐
- Diagnosis of cancer, malnutrition, HIV ☐

If 4 or more risk factors are checked, initiate Dietary Consult. ☐

FALL RISK ASSESSMENT

Assign Score:

History of falls	☐	5
Impaired mobility /gait / balance	☐	5
Incontinent / noncompliant	☐	5
Elimination with assistance	☐	5
Confused/disoriented	☐	5
Age 70 or older	☐	3
Confined to chair or bed	☐	3
Hearing impairment	☐	2
Visual impairment	☐	2
Syncope/dizziness	☐	2
Drug and/or alcohol abuse	☐	2
Requires assistance devices walk/transfer	☐	3
Bowel prep/laxatives/diuretics	☐	2
Pain meds/anesthesia/sedation	☐	2
Language or communication barriers	☐	1

Total Score _____

Point Total 0-9 LOW to MODERATE RISK Fall Risk Protocol A
Point Total ? 10 High Risk Fall Risk Protocol B

Protocol A:
- ☐ Ensure rehab consult ordered
- ☐ Educate patient/family on risk/fall prevention interventions
- ☐ Ensure adequate lighting/clear clutter on floor in room
- ☐ Provide nonslip footwear
- ☐ Observe sleep/elimination patterns, offer assist q2-4hr and prn
- ☐ Call light, phone, personal items within reach
- ☐ Bed in low position, wheels locked, at least one side-rail up
- ☐ Review medications for adverse reactions/time schedules

Protocol B:
- ☐ All of Protocol A and including the following:
- ☐ Place LAMP sign on door frame
- ☐ Increase monitoring of elimination needs to q2hr and prn
- ☐ Move patient near nurses station
- ☐ Leave bathroom light on during evening/nighttime hours
- ☐ Place both side-rails up at all times
- ☐ Involve family for assistance during high risk times
- ☐ Consult physician regarding use of restraints

Completed by: _____ Date: _____ Time: _____

ADMISSION PHYSICAL ASSESSMENT

NEUROLOGICAL

	Admission	Re-eval
WNL: Alert, oriented X3, Behavior Calm, Appropriate for situation/age. Speech clear And coherent able to voice needs. PERRLA		
Exceptions: Lethargic		
Unresponsive		
Disoriented to place		
Disoriented to time		
Slurred speech		
Aphasic		
Anxious		
Irritable		
Agitated		
Combative		
Pupils abnormal		
Headache		
Dizziness		
Visual impairment		
Hard of hearing		
Tinnitus		
Paresthesia		
Paralysis		
Other:		

PULMONARY

	Admission	Re-eval
WNL: Respirations even, unlabored, quiet. Rate 12-28 at rest. Breath sounds clear all lung fields Chest expands symmetrically. Sputum, if any, Thin, dear, Mucous membranes moist, pink. Nail beds pink.		
Exceptions: Labored respirations		
Shallow respirations		
Irregular or rapid pattern		
Shortness of breath		
Diminished breath sounds		
Wheezing		
Rhonchi		
Crackles		
Sputum thick, yellow		
Dry mucous membranes		
Ashen mucous membranes		
Nail beds thick/clubbing		
02 support Nasal cannula		
Mask		
Tracheotomy		
Resp support Ventilator		
BPAP		
Chest tube		
Other:		

CARDIOVASCULAR

	Admission	Re-eval
WNL : Normal heart sounds. Heart rate 60-100 at rest. Normal BP for age. No JVD peripheral pulses palpable. Brisk capillary refill. No edema No calf tenderness. Skin warm and dry.		
Exceptions: Irregular heart rate		
Abnormal heart sounds		
Jugular vein distension		
Palpitations		
Chest pain		
Symptomatic bradycardia		
Tachycardia		
Hypertension		
Orthostatic hypotension		
Faint peripheral pulses		
Edema: +1-+4		
Delayed capillary refill		
+ Homen's sign		
Extremities cool		
Discolored hands/feet		
Pacemaker		
Telemetry Rhythm		
Rate		
Other:		

INTEGUMENTARY

	Admission	Re-eval
WNL : Skin warm, dry, and intact color is normal, Good turgor, No skin breakdown		
Exceptions: Cool skin		
Hot skin		
Diaphoretic		
Pale		
Flushed		
Mottled		
Jaundiced		
Petechiae		
Eczema		
Rash		
Bruise		
Scar(s)		
Lesion(s)		
Skin tear(s)		
Incision(s)		
Wounds(s)		
Indwelling Line(s)		
*If skin integrity impaired, initial wound assessment form completed.		
Other:		

MUSCULOSKELETAL

	Admission	Re-eval
WNL : Extremities present, intact. Active ROM in all extremities, strength Symmetrical. No joint pain or swelling.		
Exceptions: Limited ROM - Arms		
Limited ROM - Legs		
Contractures - Mild		
Moderate		
Severe		
Amputation		
Immobility		
Muscle weakness		
Paralysis		
Poor muscle tone		
Joint pain / swelling		
Other:		

GASTROINTESTINAL

	Admission	Re-eval
WNL: Abdomen soft, non-distended. Bowel sounds present X4 quadrants. Tolerating current diet. Continent, with soft BMs, with regular frequency.		
Exceptions: Abdomen distended		
Tender when palpated		
Bowel sounds - Hypo		
Hyper		
Nausea and/or vomiting		
NGT / Peg tube		
Constipated		
Diarrhea		
Incontinent		
Fecal bag		
Colostomy		
BM - Hard		
Loose		
Dark green, tarry		
Frank blood		
Other:		

GENITOURINARY

	Admission	Re-eval
WNL: Voids without dysuria. Continent. Bladder non-distended, fully empties, Urine is clear, yellow to light amber.		
Exceptions: Incontinent		
Foley / suprapubic cath		
Condom cath		
Cloudy urine		
Bloody urine		
Painful urination		
Burning		
Retention		
Frequency		
Other:		

Completed by: _____ Date: _____ Time: _____

INITIAL PAIN ASSESSMENT

Is patient currently in pain? Yes ☐ No ☐

Is your pain constant? Yes ☐ No ☐

Or is your pain intermittent? Yes ☐ No ☐

Location of pain? _____

When did pain begin? _____

Reason for pain known? _____

What makes pain worse? _____

How would you describe your pain?

Shooting	☐	Ache	☐	Burning	☐
Stabbing	☐	Pull	☐	Pins and Needles	☐
Throbbing	☐	Dull	☐	Spasms	☐
Prick	☐	Sharp	☐	Other _____	☐

VERBAL PAIN SCALE

On a scale of 1-10, with 0 being no pain and 10 being the worst pain possible, rate the intensity of your pain

	0	1	2	3	4	5	6	7	8	9	10
Right now	No pain				Moderate pain					Worst possible pain	
Highest it has been	No pain				Moderate pain					Worst possible pain	
Lowest it has been	No pain				Moderate pain					Worst possible pain	

NON-VERBAL PAIN SCALE

(A) (B) (C) (D) (E)

Which is affected by pain?
- Sleep ☐
- Appetite ☐
- Elimination ☐
- Activity ☐
- Mood ☐
- Other ☐

What helps the pain?
- Medication _____ ☐
- Sleep / Rest ☐
- Application of heat / Cold ☐
- Repositioning / massage ☐
- Relaxation techniques ☐
- Exercise ☐

Is there anything else you want to tell about the pain? (Use patient's own words) _____

Time	Pain Level Verbal / Nonverbal	Location	Intervention	Time of Re-eval	Pain Level Verbal/Non	Initials

Signature	Initials	Signature	Initials

ORAL INTUBATION YES ☐ NO ☐				TRACH YES ☐ NO ☐		
Date:_____			1	2	3	4
ORAL CARE ASSESSMENT GUIDE	Lips	1 2 3 4	Smooth Pink, moist intact	Slightly Wrinkled and dry, one or more isolated reddened areas	Dry and somewhat swollen; may have 1 or 2 isolated blisters inflammatory line of demarcation	Extremely dry and edematous; entire lip inflamed; generalized blisters or ulceration
	Gingiva & Oral Mucosa	1 2 3 4	Smooth pink, moist intact	Pale and slightly dry; 1 or 2 lesion blisters or reddened areas	Dry and somewhat swollen; generalized redness; more than 2 isolated lesions blisters or reddened areas	Extremely dry and edematous; entire mucosa red and inflamed; multiple confluent ulcers
	Tongue	1 2 3 4	Smooth pink, moist intact	Slightly dry; 1 or 2 isolated reddened areas papillae prominent. While coating	Dry and somewhat swollen; generalized redness but tip, and papillae are reddened 1 or 2 isolated lesions or blisters	Extremely dry and edematous; thick and engorged; entire tongue quite inflamed; tip very red and demarcated with coating; multiple blisters or ulcers
	Saliva	1 2 3 4	Watery, plentiful	Increased thickness	Scanty may be thicker than normal	Tick and ropey, viscid, or mucoid
	Teeth	1 2 3 4	Clean, no debris	Minimal debris, mostly between teeth	Moderate debris clinging to half of visible enamel	Covered with debris

COMMENTS / NOTES

Date	Time	

COMMENTS / NOTES

Date	Time	

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