Date of Arrival: ______ Time: ______ Unit Admitted: ______ Room #: ______

Mode of Arrival: ❑ Ambulatory ❑ Wheelchair ❑ Stretcher or Bed Admitted From: ❑ Home ❑ ED ❑ PACU ❑ Other: ______

ADMISSION VITAL SIGNS (Completed on Admission to Inpatient Unit – RN, LPN or PCT)

Temp: ______	Pulse: ______	Resp: ______	BP:	SPO2 ______ %
❑ Tympanic ❑ Oral ❑ Rectal	❑ Radial ❑ Brachial ❑ Apical		❑ R Arm ______ ❑ L Arm ______ ❑ Sitting Position ❑ Lying Position	**(SD, CC and Related DX)** ❑ Room Air ❑ O2 at ______ liters

Weight: ______ ❑ Actual Weight (Preferred) ❑ Stated Weight **Height:** ______ ❑ Actual ❑ Stated

Associate Name (Print): ______ **Title:** ❑ **RN** ❑ **LPN** ❑ **PCT**

Source of Information: ❑ Patient ❑ Other, Name: ______ Relationship to Patient: ______

❑ Transfer Form ❑ Unable to Obtain History Reason: ______

Emergency Contact #'s: ______ Name: ______ Relationship: ______

Complaints or Symptoms or Reason for Hospitalization:

Check and Circle All that Apply. Nurse: RED TYPE FONT indicates Risk Factor for Venous Thromboembolism (VTE) including DVT & PE.

PATIENT HISTORY

MEDICAL DEVICES: ❑ NONE
- ❑ AICD / Pacemaker
- ❑ Indwelling Central Venous Catheter Type: ______
- ❑ Indwelling Urine Catheter or Suprapubic Insertion Date: ______
- ❑ Insulin Pump ❑ IV Pump
- Other: ______

RESPIRATORY
- ❑ Asthma / Bronchitis
- ❑ Sinusitis
- ❑ COPD / Emphysema / Respiratory Failure
- ❑ Pneumonia
- ❑ Sleep Apnea / Loud Snoring
- ❑ Shortness of Breath
- ❑ Tracheostomy
- ❑ Current Smoker

CARDIO-PERIPHERAL VASCULAR
- ❑ Chest Pain / Angina
- ❑ Heart Attack – Date: ______
- ❑ Heart Failure
- ❑ High Blood Pressure
- ❑ Irregular Heart Rhythm
- ❑ Palpitations ❑ Heart Murmur
- ❑ Aortic Aneurysm
- ❑ Coronary Bypass – Date: ______
- ❑ Peripheral Vascular Insufficiency (PVD)
- ❑ Peripheral Arterial Disease (PAD)
- ❑ Varicose Veins / Phlebitis
- ❑ History of Blood Clot (DVT or PE)

ENDOCRINE
- ❑ Diabetes: ______
- ❑ Thyroid: ______
- Other: ______

MUSCULAR SKELETAL
- ❑ Osteoarthritis ❑ Rheumatoid Arthritis Location: ______
- ❑ Joint Replacement – Date: ______ Location: ______
- ❑ Fracture History – Date: ______ Location: ______
- ❑ Back / Disc Problems ❑ Gout
- ❑ Cellulitis / Soft Tissue Infection

NEUROLOGICAL
- ❑ History of Falls within Past 3 Months
- ❑ Stroke / TIA
- ❑ Paralysis (Hemi or Paraplegia)
- ❑ Epilepsy / Seizures
- ❑ Parasthesias / Numbness / Tingling
- ❑ Balance / Gait Disturbances
- ❑ Parkinson's Disease
- ❑ Dizziness / Fainting / Syncope
- ❑ Headaches / Migraines
- ❑ Confusion / Disorientation
- ❑ Alzheimer's / Dementia
- ❑ Head Injury or Trauma

GASTROINTESTINAL
- ❑ Inflammatory Bowel / Chron's / Colitis
- ❑ Current Complaint: Diarrhea
- ❑ Current Complaint: Nausea / Vomiting
- ❑ Constipation ❑ Fecal Incontinence
- ❑ Acid Reflux / GERD / Heartburn
- ❑ Peptic or Gastric Ulcers
- ❑ Hernia: ______
- ❑ Ostomy: ______
- ❑ Cirrhosis / Hepatitis / Jaundice
- ❑ Blood in Stool

GENITO-REPRODUCTIVE
- ❑ Pregnant ______ wks ❑ Lactating
- ❑ Birth Control Pills / Hormone Replacement
- ❑ Last Menstrual Period: ______
- ❑ Vaginal Discharge: ______
- ❑ Penile Discharge

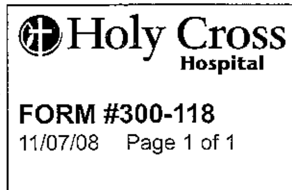
RENAL-URINARY
- ❑ Renal Failure / Renal Insufficiency
- ❑ Hemo-Dialysis / Peritoneal Dialysis
- ❑ Prostate Problems: ______
- ❑ Kidney Stones
- ❑ Urinary Retention / Pain on Urination
- ❑ Frequent Urination ❑ Urine Incontinence

GENERAL
- ❑ Admitted for Abdominal, Gyne Surgery
- ❑ Admitted for Total Joint Replacement
- ❑ Admitted to Critical Care
- ❑ Admitted Bone Fracture or Trauma
- ❑ 40 Years Old or Greater
- ❑ Obesity
- ❑ Current Infection or Sepsis
- ❑ Systemic Lupus
- ❑ Collagen Disease
- ❑ Sickle Cell / Hypercoagulopathy
- ❑ Cancer: ______
- ❑ Current Chemotherapy / Radiation Therapy
- ❑ HIV / AIDS
- ❑ Birth Defect: ______
- ❑ Organ Transplant Recipient
- ❑ Other: ______
- ❑ Participating in Research Study*

Nurse: Call Ext. 3239 to Notify that Patient is part of Research Study / Clinical Trial.

TO BE COMPLETED BY NURSE:

❑ Patient has 2 or More VTE Risk Factors and VTE PROTOCOL Placed on Chart – Nurse Initial: ______



FORM #300-118

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TO BE COMPLETED BY PRE-ADMIT RN

❑ Phone Interview ❑ Patient Visit

Date of surgery: ______ Instructed time of arrival: ______

Procedure: ______ Surgeon: ______

❑ Instructed on NPO ❑ Instructed to bring a copy of AD

❑ Other instructions: ______

PATIENT LABEL

PATIENT DATA BASE

THESE SECTIONS TO BE COMPLETED BY THE PATIENT, RN, LPN OR PRE-SCREENING NURSE / PRE-OP HOLDING NURSE
(RN must review all areas completed by Patient, Family or LPN)

PREVIOUS HOSPITALIZATIONS / SURGERIES? ❑ NO ❑ YES – If YES, list year and reason for hospitalization and year and type of surgery:

____

____

____

____

____

ANESTHESIA / SEDATION REACTIONS

1. Have you had complications with anesthesia or sedation? ❑ Never had anesthesia / sedation ❑ NO ❑ YES
   If YES, Describe: ❑ Blood pressure problems ❑ Breathing problems ❑ High fever ❑ Slow to awaken
2. Have you had a blood transfusion? ❑ NO ❑ I Don't Know ❑ YES If YES, did you have a reaction? ❑ NO ❑ YES
   Would you accept blood products in emergencies? ❑ NO ❑ YES
   If NO, Is it due to religious beliefs? ❑ NO ❑ YES – ❑ Jehovah's Witness ❑ Other Religion: ______________

INFECTION HISTORY

Do you have a history of a multi-drug resistant infection or colonization such as:

1. MRSA (Methicillin Resistant Staff Aureus)?............................❑ NO ❑ Don't Know ❑ YES
2. Vancomycin Resistant Enterococcus (VRE)?..........................❑ NO ❑ Don't Know ❑ YES
3. C-Difficile with current symptoms of Diarrhea, Abdominal Pain?.....❑ NO ❑ Don't Know ❑ YES
   If YES, place on Contact Precautions and Notify Physician.
4. Are you being treated for TB or do you have persistent cough greater than 2 weeks with any of the following: Bloody Sputum, Fever, Night Sweats, Weight Loss, Shortness of Breath?....................❑ NO ❑ YES
   If YES, place on Airborne Precautions and Notify Physician.

PAIN SCREEN / PAIN HISTORY

1. Do you have pain now or within past week?.........................❑ NO ❑ YES
2. Do you suffer from chronic (long-standing) pain? ....❑ NO ❑ YES
   If answer is NO to both questions, STOP HERE. If any YES to either, complete below:

	Location A	Location B	Location C	Location D
Location – Where is your pain?				
Quality – What does it feel like?				
Intensity – Rate your pain on a 0-10 scale **0=No pain 10=Worse pain ever experienced**				
Frequency – Is this pain continuous or on and off?				

Which activities does your pain interfere with? ❑ None ❑ Activities of Daily Living ❑ Sleep ❑ Appetite ❑ Concentration ❑ Mood or Emotional Health ❑ Ability to Work ❑ Ability to Enjoy Sports ❑ Social Relationships

What helps or reduces the pain? ❑ Heat ❑ Cold Packs ❑ Rest ❑ Certain Positions ❑ Medications ❑ TENS Unit

SOCIAL

Have you used the following?

Tobacco ❑ NO ❑ YES Type: ______________ Amount per Day: ________ How Long? ____-____ Last Used? ________

Recreational Drugs ❑ NO ❑ YES Type: ______________ Amount per Day: ________ How Long? ____-____ Last Used? ________

Alcohol ❑ NO ❑ YES Last Used? __________ If YES, complete ETOH Screen below.

ETOH SCREEN

Risk Screen for Alcohol Withdrawal

1. Do you drink 2 to 3 drinks daily?..❑ NO ❑ YES
2. Patient admitted with acute intoxication? ....❑ NO ❑ YES
3. History of DT's or alcohol withdrawal history?...................................❑ NO ❑ YES
4. Has habitual alcohol use?..❑ NO ❑ YES

Patients who meet one or more of the above criteria – Call Physician and suggest ALCOHOL WITHDRAWAL SYNDROME ORDERS (Form #200-105).

THESE SECTIONS TO BE COMPLETED BY
THE PATIENT, RN, LPN OR PRE-SCREENING NURSE / PRE-OP HOLDING NURSE
(RN must review all areas completed by Patient, Family or LPN)

SUICIDE SCREEN

Suicide Attempt? ❑ NO ❑ YES **Stated Intent to Harm Self:** ❑ NO ❑ YES If One YES, Nurse to Notify Physician.

CONTINUUM OF CARE

Residence: ❑ Private Home ❑ Assisted Living Facility ❑ Nursing Home ❑ Other: ____________
Facility Name: ____________

Lives: ❑ Alone **Lives With:** ❑ Spouse / Partner ❑ Family ❑ Friend Name: ____________ ❑ Private Aide

Current Services: ❑ None ❑ Meals on Wheels ❑ Oxygen ❑ Private Duty
❑ Home Health – Agency Name: ____________

Activity Prior to Admission: ❑ Walks Unaided ❑ Cane ❑ Walker ❑ Wheelchair ❑ Bed-Ridden

PRELIMINARY PLAN: Return to Prior Residence with: ❑ No Services ❑ Home Health ❑ Equipment
❑ Rehab Facility ❑ Outpatient Services ❑ Nursing Home Placement ❑ Unknown at this Time

ADVANCE DIRECTIVE

❑ **Unable to Obtain AD Information Due to Clinical Condition**

1. Do you have an Advanced Directive (AD)? .... ❑ NO – **Stop Here** ❑ **YES – If YES Complete Question #2.**
2. Does the Hospital have a copy of the AD THIS Admission? .... ❑ YES ❑ **NO – If no, Complete Question #3.**
3. What are your wishes expressed in your Advanced Directive? My Advanced Directive says if I am in terminal condition:
   - **a.** I want to be placed on a mechanical respirator to keep me breathing if in a terminal condition .... ❑ NO ❑ YES
   - **b.** I want Cardiopulmonary Resuscitation Chest Compressions and Artificial Breathing .... ❑ NO ❑ YES
   - **c.** Should I be unable to eat, I want a feeding tube or to be fed through artificial means .... ❑ NO ❑ YES

NOTE: Your AD only goes into effect when your physician determines you have an end-stage or terminal condition or disease and you cannot make informed decisions due to your deteriorating condition.

I understand that I can change my mind at any time. I also understand and agree that this document will serve as a record of the substance and intent of my existing advance directive if a copy is not available or provided to the Hospital. If a copy of AD is provided, the wishes in the AD shall be honored.

Patient Signature ONLY: ____________ **Date:** ____________

PATIENT EDUCATION

The Patient Education / Discharge Instruction Folder has been given to me which includes the following information:

- **a.** Smoking Cessation Education – "How Can I Quit Smoking?"
- **b.** Pain Brochure – "Understanding Your Pain - Using a Pain Rating Scale"
- **c.** Vaccine Information Sheets – Pneumococcal Vaccine and Influenza Vaccine (October - March Only)
- **d.** Fall Prevention Brochure – "How You Can Help Prevent A Fall In The Hospital".
- **e.** Patient Safety Brochure
- **f.** Preventing Blood Clots – "Learn About VTE - Take Steps to Prevent Them"
- **g.** Stroke – "Let's Learn About Stroke and TIA"

By signing below, I (or other relation) acknowledge receipt of the above education / information and affirm that the medical history provided is accurate.

Patient / Other Signature: ____________ **Relationship:** ____________ **Date:** ____________

THIS SECTION IS COMPLETED BY THE RN OR PRE-OP HOLDING NURSE

SKIN AND PRESSURE POINTS

❑ **No Skin Breakdown or Redness** on Coccyx, Buttock, Trochanters, Malleolus Heels ❑ **Skin Breakdown Present on Admission**
KEY: P=Pressure A=Abrasions ST=Skin Tear BL=Blister BR=Bruising B=Burns VU=Vascular Ulcers R=Rash SW=Surgical

WOUND:

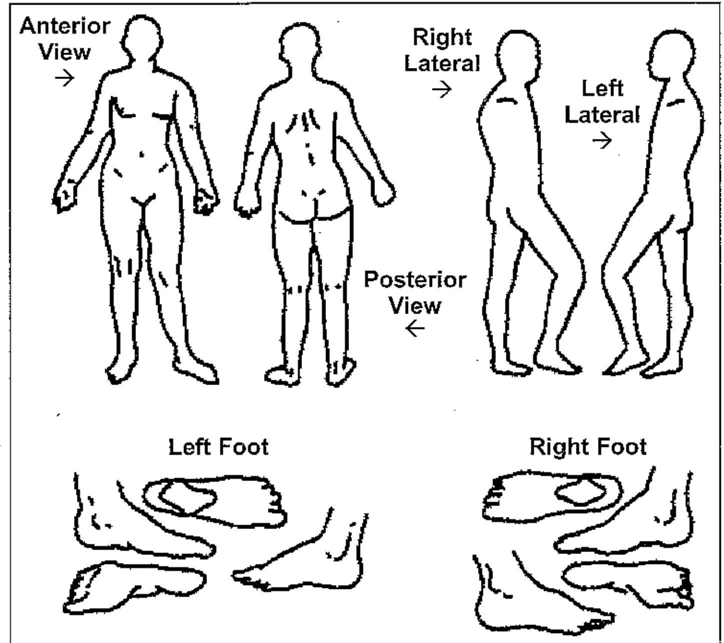
A. Location: ______________________________
❑ Pressure Ulcer Stage: ______________ Size: __________
❑ Other Wound – Describe: ______________________________
____

B. Location: ______________________________
❑ Pressure Ulcer Stage: ______________ Size: __________
❑ Other Wound – Describe: ______________________________
____

C. Location: ______________________________
❑ Pressure Ulcer Stage: ______________ Size: __________
❑ Other Wound – Describe: ______________________________
____

D. Location: ______________________________
❑ Pressure Ulcer Stage: ______________ Size: __________
❑ Other Wound – Describe: ______________________________
____

MARK LOCATION



❑ **ALTERED SKIN INTEGRITY FLOWSHEET INITIATED (FORM #300-037)**
❑ **PHOTOGRAPH TAKEN** ❑ **PRESSURE REDISTRIBUTION MATTRESS**
NOTE: USE UNIT FLOW SHEET TO RECORD BRADEN SCORE AND PREVENTION MEASURES IMPLEMENTED

THIS SECTION IS COMPLETED BY A PCT, LPN OR RN

HOSPITAL ORIENTATION AND PATIENT SAFETY

❑ Correct ID Band Present on Wrist / Leg
❑ Call Light
❑ Visiting Hours
❑ No Children Under 12 Years
❑ No More than 2 Visitors at a Time
❑ TV
❑ Hospital Orientation: Channel 3 (Airs: 8a, 10a, 1p, 4p, 7p, 11p)
❑ Education Channels
❑ Bed Controls
❑ Telephone
❑ NO SMOKING POLICY
❑ Bathroom Call Light
❑ Availability of Spiritual Care
❑ Meal Times
❑ Handwashing
❑ Isolation Procedures

SIGNATURES

SIGNATURES OF PERSONS COMPLETING HISTORY:

Patient / Other Signature: ______________________ **Relationship:** ______________________ **Date:** __________

Pre-Admit RN (PRINT Name): ______________________ **Pre-Admit RN Signature:** ______________________ **Date:** __________

LPN (PRINT Name): ______________________ **LPN Signature:** ______________________ **Date:** __________

Admitting RN (PRINT Name): ______________________ **Admitting RN Signature:** ______________ **Date:** __________ **Time:** ______

(RN IS TO REVIEW FOR COMPLETENESS AND ACCURACY AND SIGN WHEN HISTORY IS COMPLETED BY PATIENT OR LPN)