

Name: _____ Age: _____ Phone #: _____ Date: _____ Time: _____
 Primary Physician: _____ / Surgeon: _____ Phone #: _____
 Chief Complaints/Procedure: _____ Height: _____ Actual Weight (lbs.): _____
 Historian: _____ Temp: _____ Pulse: _____ Resp: _____ BP: _____ O₂ Sat: _____
 Religious Affiliation: _____ Patient refuses blood/blood products Hospitalized within 30 days: Yes No

UNABLE TO OBTAIN HISTORY <input type="checkbox"/> Reason: _____ NEUROLOGICAL/SENSORY PERCEPTION Denies History <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing Loss/Deaf Right <input type="checkbox"/> Left <input type="checkbox"/> Motion Sickness <input type="checkbox"/> Paresthesia Right <input type="checkbox"/> Left <input type="checkbox"/> Fibromyalgia/Migraine <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Stroke/CVA/TIA <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Other: _____ CARDIOVASCULAR/HEMATOLOGY Denies History <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Blood transfusion in the past 3 months <input type="checkbox"/> Chest Pain/Angina <input type="checkbox"/> Heart Attack/Date: <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Beats/Pacemaker/AICD <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Murmur <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Venous Access Device/Type <input type="checkbox"/> Other: _____ RESPIRATORY Denies History <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Post Nasal Drip/Rhinitis/Sinusitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other: _____	GASTROINTESTINAL Denies History <input type="checkbox"/> Dysphagia <input type="checkbox"/> Gall Stones <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Liver Disease/Jaundice <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Ostomy <input type="checkbox"/> Last Bowel Movement: _____ Other: _____ GENITOURINARY/RENAL Denies History <input type="checkbox"/> Kidney Disease/Urogenital <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Voiding Problems <input type="checkbox"/> Other: _____ MUSCULOSKELETAL Denies History <input type="checkbox"/> Arthritis <input type="checkbox"/> Back/Disc Problem <input type="checkbox"/> Fractures <input type="checkbox"/> Other: _____ ENDOCRINE Denies History <input type="checkbox"/> Diabetes/type: <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Other: _____ INFECTIOUS DISEASE Denies History <input type="checkbox"/> Fevers <input type="checkbox"/> Hepatitis/type/active <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Recent Cold <input type="checkbox"/> Sexually Transmitted Disease/type <input type="checkbox"/> Tuberculosis/Active: <input type="checkbox"/> Other: _____	WOMENS HEALTH Denies History <input type="checkbox"/> Pregnant <input type="checkbox"/> Lactating <input type="checkbox"/> LMP/Date: _____ BEHAVIORAL HEALTH Denies History <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Suicide (thoughts/attempts) <input type="checkbox"/> Patient is a Baker Act <input type="checkbox"/> Other: _____ CANCER Denies History <input type="checkbox"/> Type <input type="checkbox"/> Radioactive Seeds/Implant <input type="checkbox"/> Date: _____ Chemo: _____ Tx Date: _____ SOCIAL HISTORY Denies History <input type="checkbox"/> Tobacco <input type="checkbox"/> Number of years: _____ # of packs per day: _____ Year Quit: _____ Potential for alcohol withdrawal if: 1. PT consumes alcohol daily 2. PT is acutely intoxicated 3. PT has previous history of DT's 4. PT is habitual alcohol user Alcohol <input type="checkbox"/> Drinks per day: _____ Last drink taken: _____ Amount: _____ Type: _____ When quit drinking: _____ Recreational Drug <input type="checkbox"/> Amount: _____ Type: _____ Year Quit: _____ Detoxification Protocol Initiated <input type="checkbox"/>
--	---	--

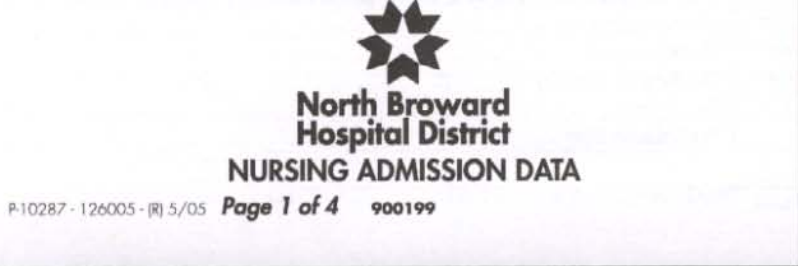
ALLERGIES & REACTION Latex Latex Allergy Protocol Implemented None Known Blood Reaction Allergy Bracelet on

Medications: _____ **Symptoms:** _____

<input type="checkbox"/> Food/Shellfish/other allergies:					
<input type="checkbox"/> Contrast/Dye:					
PAST HOSPITAL/PROCEDURE (Surgical/Medical/Behavioral Health)	CURRENT MEDICATIONS (include ASA/Anticoagulant, over the counter medications, ointments, patches, eye drops, herbal, vitamins and nutritional supplements)				
	Medication	Dose	Frequency	Last Dose	In-patient Prescription
					Y or N
					Y or N
					Y or N
					Y or N
					Y or N
					Y or N
					Y or N

Initiate Social Service Consult (Note: Additional medication can be listed on last page) Attending Physician Notified of all medications

ADDRESSOGRAPH



PAIN HISTORY



Have you been experiencing pain? Yes No
 If yes, how long? _____ Intensity (0-10): _____ Goal (0-10): _____
 Location: _____
 Radiation: _____
 Duration: _____
 Quality: _____
 Aggravating factors: _____
 What medications/interventions are effective in relieving your pain?

PSYCHOSOCIAL ASSESSMENT

Lives alone Lives with spouse/SO Nursing Home/ALF
 Homeless Rehab Facility Other: _____
 Marital Status Single Married Divorced Widowed Separated
 Next of Kin: _____ Phone #: _____
 Supportive Adult/Guardian: _____
 Phone #: _____
 (Inform patient to provide guardianship form within 24 hours)
 Has anybody threatened/hit/abused you within the last year?
 Yes (refer to policy RA 004015) No

EDUCATIONAL LEARNING ASSESSMENT

Learner Patient Family Significant Other
Readiness to learn Eager to learn Asks questions
 Extremely anxious Denies need for Education
Knowledge of current health status No knowledge
 Partial understanding Full understanding
Barriers to learning Physical Emotional
 Language Religious Cultural
 Reading Ability Changes in Short Memory
 None
Preferred Learning Method Reading Lecture
 Video Demo/Practice
Communication English Spanish Creole
 Sign Language Other: _____
 Do you have any religious/cultural practices that are important to you or may alter your care or education? No Yes
 Patient Handbook Provided

PERSONAL EFFECTS: Do you use the following:

	YES	WITH PT.	FAMILY/SO
Purse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wallet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Braces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cane/Crutches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures: (Full)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient/Family Signature _____ **Date** _____
 The party signed above has assumed responsibility for the above.

Initiate Social Service Consult

ADVANCE DIRECTIVES

Do you have an Advance Directive?
 (must check one of the following)
No. Information provided to patient
No. Patient elects not to receive information
No. Patient unable to respond/family unavailable
Yes. Please check the applicable Advance Directive(s)
 Living Will Health Care Surrogate Durable Power of Attorney
 If yes, patient has an Advance Directive, **must check one**
 Copy in chart now if patient does not have advance directive with them please request/check one of the following:
 New Advance Directive obtained and on chart
 Verbalized intent (must notify MD)
 Elects not to provide information

Are you an Organ Donor: Yes No

DEEP VEIN THROMBOSIS SCREEN

If the patient has restricted mobility with two other risk factors, please notify the Physician
Risk Factors:
Restricted mobility Trauma
 Age > 40 years Hip Fracture
 History of DVT Pregnancy
 Myocardial Infarction Estrogen Therapy
 Congestive Heart Failure Birth Control Pill Use
 Pneumonia Cancer
 Paralysis Sepsis
 Non-Hemorrhagic Stroke
 Renal Disease
 Varicose Veins
 Central Line
 Obesity
 Lupus
 Hyper Coagulopathy
 Physician notified regarding above risk factors.

PLANNED SURGICAL INTERVENTION:

Abdominal Surgery
 Gynecological Surgery
 Fracture Reduction
 Total Joint Replacement
 Knee/Lower Extremity Surgery

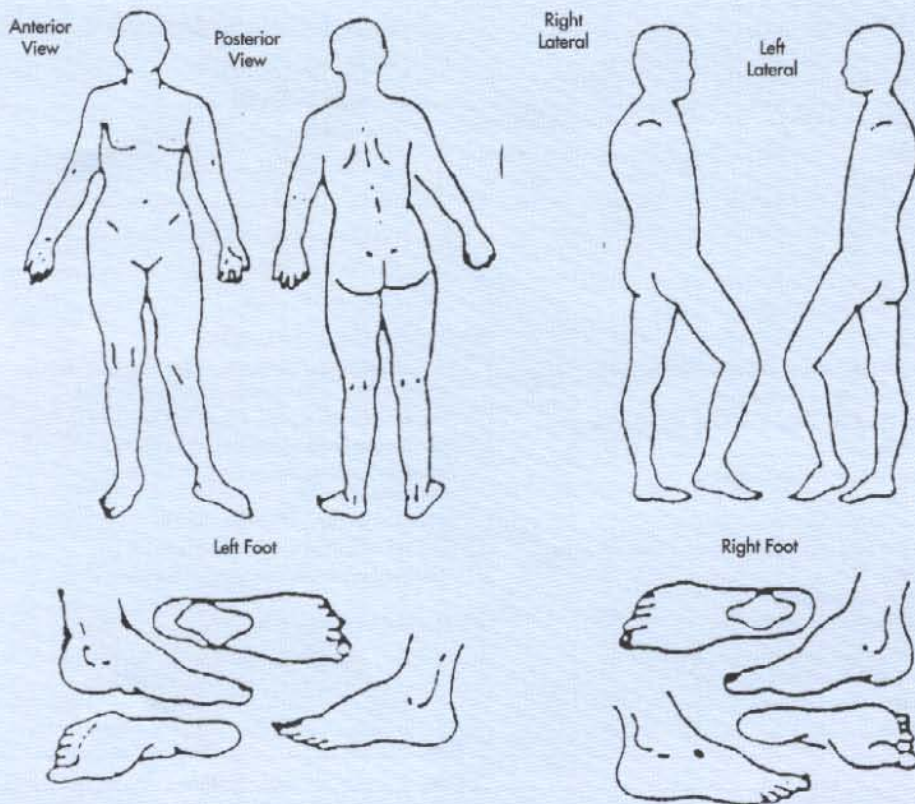
NUTRITIONAL SCREEN: If any of the following are checked, request for Nutritional Consult Ordered

Altered Mental Status
 Nausea/vomiting > 5 days
 No food/drink for 3 days
 Recent unplanned weight loss > 10 lbs.
 Difficulty swallowing/dysphagia
 Evidence of Stage III - IV pressure ulcer/Complicated wounds
 Feeding tube
 New onset diabetes
 Trauma
 TPN
 Bariatric Diet
 Pregnant/lactating
 Surgical patients > 70 years of age
 Ethnic diet/special needs (include in diet order and order for Preference consult)
 Difficulty chewing (include in diet order and order for Preference consult)
No Criteria Met

FUNCTIONAL SCREEN: If any of the following are checked, physician order for physical therapy consult requested

New onset of paralysis
 New onset stroke/CVA/syncope/hypotension
 New amputation
 Unsteady gait
 Decreased mobility
 Dysphagia
No Criteria Met

MARK LOCATION



* Label Wound Type

WOUND TYPE

- | | |
|--------------------|----------------------|
| P = Pressure ulcer | T = Traumatic |
| ST = Skin tear | A = Abrasions |
| S = Surgical | LU = Leg/Foot ulcers |
| L = Laceration | BR = Bruising |
| B = Burns | O = Other |

STAGE

Pressure ulcer only

- I: Reddened area, does not resolve with pressure relief.
- II: Blister or superficial break in skin.
- III: Full thickness wound into subcutaneous tissue.
- IV: Full thickness with muscle, bone or tendon tissue exposed.
- U = Unable to stage: Necrotic

Skin Breakdown Present Not Present Photograph Taken If wounds present: Acute/Chronic Wound Flow Sheet Initiated

PNEUMOCOCCAL VACCINE
*May be administered year round

INFLUENZA VACCINE
*May be administered September through March

ASSESSMENT

CHECK ALL WHICH APPLY TO PATIENT

- Unable to determine prior vaccination status
- For Pneumonia:
 - Patient has not received vaccine (order set on chart)
 - Patient has received vaccination in past 5 years (<65 years old)
 - Patient is 65 years of age or older and has received vaccination since the age of 65

ASSESSMENT

CHECK ALL WHICH APPLY TO PATIENT

- Unable to determine prior vaccination status
- For Influenza:
 - Patient has not received vaccine (order set on chart)
 - Patient has received vaccination this current flu season

ANTICIPATED DISCHARGE NEEDS Social Services Consult entered in computer

Transportation Placement needed

Medical Equipment: Oxygen CPAP Nebulizer Blood Glucose Meter Other: _____

Community Services: (Home Health, Reach to Recovery, Meals On Wheels, etc.): _____

Nurse Signature: _____ Unit: _____ Date: _____ Time: _____

Nurse Signature: _____ Unit: _____ Date: _____ Time: _____

