**Nursing Admission Assessment**

Date: __________ Time: ___________

Informant: □ Patient □ Other ______________ Phone #: ____________________________

Mode of access: □ Ambulatory □ WC □ Stretcher □ Other ____________________________

Transported with: □ Oxygen □ Monitor □ IV □ Other ________________________________

From: □ Home □ ER □ Dr. Off. □ AFC □ ECF □ Other ________________________________

Accompanied by: ________________________________________________________________ □ Lock-up

Valuables: □ None □ Sent home with ________________________________________________ □ Lock-up

Reason for Admission (Pt’s own words):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

**Vital Signs**

<table>
<thead>
<tr>
<th>T</th>
<th>O R A T</th>
<th>P</th>
<th>Reg</th>
<th>SaO₂</th>
<th>R</th>
<th>BP</th>
<th>Ht</th>
<th>Wt</th>
<th>S</th>
<th>Kg</th>
</tr>
</thead>
</table>

**Allergies**

<table>
<thead>
<tr>
<th>Latex? Y or N</th>
<th>Allergies</th>
<th>Reaction</th>
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</thead>
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**Chronic conditions:**

□ Lung Problems □ Stomach Problems □ Thyroid Problems □ Neurological Problems □

□ Heart Problems □ Liver Problems □ Vision Problems □ Kidney Problems □

□ Arthritis □ Diabetes □ Chronic infection □ Treatment: ____________________________

□ Cancer (where/type) □ Other Past Medical History or Surgeries:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

□ Family history – □ NSF □ Heart disease □ Hypertension □ Diabetes □ Stroke □ Seizures □ Kidney disease □ Liver disease

**Medications**

<table>
<thead>
<tr>
<th>Medication (Include OTC)</th>
<th>Dose</th>
<th>Frequency</th>
<th>Taken today? Y or N</th>
<th>Brought with? Y or N</th>
<th>Medications (Include OTC)</th>
<th>Dose</th>
<th>Frequency</th>
<th>Taken today? Y or N</th>
<th>Brought with? Y or N</th>
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</table>

**Social History**

□ Lives alone □ Lives with __________________________ □ Stairs at home □ Yes □ No □ Sleep pattern

Meds sent: □ Home with __________________________ □ Lock-up □ Not applicable □

Immunizations current? □ Yes □ No __________________________ □ Last Tetanus toxoid? ____________

Nicotine Use: □ No □ Yes – How much? _______ How Long? ____________ □ Instructed on Name of Hospital “No Smoking” Policy? □ Yes □ No □ Do you live in a smoking environment? □ Yes □ No


Social Drug Use: □ No □ Yes – Type? □ Social Services □ HHC □ Hospice □ Other □ Frequency? ____________

Support Services: □ No □ Yes – Type? □ Additional Help needed? □ No □ Yes – Referral made to ____________
Impairment / Disabilities

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Impaired hearing</td>
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<tr>
<td>Hearing Aid</td>
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<tr>
<td>Impaired vision</td>
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<td>Glasses</td>
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<td>Can perform ADL?</td>
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<tr>
<td>Contacts</td>
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<tr>
<td>Can read?</td>
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<tr>
<td>Dentures</td>
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<tr>
<td>Can write?</td>
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<tr>
<td>Partial</td>
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<tr>
<td>Prosthesis</td>
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</tbody>
</table>

Home O₂ Rate: Other:

Dietary Habits

Special Diet: ____________________________________________ Supplements: _______________________________________

Safety

☐ Yes ☐ No ID Band on ☐ Yes ☐ No Oriented to Unit ☐ Yes ☐ No Call Bell in Reach ☐ Yes ☐ No IV pump

☐ Yes ☐ No Toiletry Supplies Offered

Skin Integrity Assessment Scale: ________________________ if 17 or below, Skin Risk initiated

Fall Risk Assessment Scale: ____________________________ if above 25, Fall Prevention initiated

Skin Risk Assessment Scale

<table>
<thead>
<tr>
<th>Sensory Perception</th>
<th>Moisture</th>
<th>Activity</th>
<th>Mobility</th>
<th>Nutrition</th>
<th>Friction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to respond to pressure related discomfort</td>
<td>Skin exposed to moisture</td>
<td>Degree of physical activity</td>
<td>Ability to change and control body position</td>
<td>Food intake pattern</td>
<td>Requires assist in moving. Frequent friction. History of skin tears or pressure sores.</td>
</tr>
<tr>
<td>2. Very limited – response to painful stimuli or limits ability to feel pain over ½ of body, or paralysis present</td>
<td>2. Very moist – extra linen change 1x per shift</td>
<td>2. Chair fast – NWB/WC must be assisted to chair</td>
<td>2. Very limited – unable to make frequent changes independently</td>
<td>2. Inadequate – eats &lt; ½ meal. Takes less than optimum</td>
<td>2. Potential – requires minimum assist, occasional friction</td>
</tr>
</tbody>
</table>

Fall Risk Assessment Scale

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confused - disoriented - hallucinating</td>
<td>20</td>
</tr>
<tr>
<td>Unstable gait, weakness</td>
<td>20</td>
</tr>
<tr>
<td>Hx of syncope or seizures</td>
<td>15</td>
</tr>
<tr>
<td>Recent hx of falls</td>
<td>15</td>
</tr>
<tr>
<td>Age 12 or younger</td>
<td>15</td>
</tr>
<tr>
<td>Paralysis, hemiplegia, stroke</td>
<td>15</td>
</tr>
<tr>
<td>Post-op condition - sedated</td>
<td>10</td>
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<tr>
<td>Narcotics, diuretics, antihypertensives, etc.</td>
<td>10</td>
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<tr>
<td>Drug or alcohol withdrawal</td>
<td>10</td>
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<tr>
<td>Bowel, bladder urgency - incontinence</td>
<td>10</td>
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<tr>
<td>Use of walker, cane, crutches, etc.</td>
<td>10</td>
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<tr>
<td>Age 70 or above</td>
<td>5</td>
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<tr>
<td>Postural hypotension</td>
<td>10</td>
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<tr>
<td>Uncooperative, impaired judgement</td>
<td>5</td>
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<tr>
<td>Poor eyesight</td>
<td>10</td>
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<tr>
<td>Language barrier</td>
<td>5</td>
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<tr>
<td>New meds (i.e. sedative, antihypertensive)</td>
<td>15</td>
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<tr>
<td>Poor hearing</td>
<td>5</td>
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</tbody>
</table>

Part II – Systems Review

* NSF = No significant findings-

Pediatrics: ☐ NA ☐ NSF

☐ Yes ☐ No Special Diet?
☐ Yes ☐ No Warmed?
☐ Yes ☐ No Diapers
☐ Yes ☐ No Immunizations current?

For children under 2 yrs: Head circ ________ Chest circ ________ Abd Circ ________
### Speech
- Pupils Size: __________________
- Deviation: ___________________

### Extremities
- ROM

### Dental Hygiene
- ___________________________

### Skin – Extremities – Musculoskeletal
- Color: ___________________
- History DVT: ________________
- Homans (R)/(L): ________________
- Tingling: ________________
- Weakness: ________________
- Deformity: ________________
- Contractures: ________________
- Replacement – Date: ________________
- Location: ________________
- Other: ____________________

### Cardiac Rate or Monitor pattern:
- ___________________________

### Cardiovascular
- JVD (R)/(L): ________________
- Pitting: ________________
- Non-pitting: ________________
- Location: ________________
- Other: ____________________

### Respiratory
- Lung sounds:
- Non-productive: ________________
- Productive – Color: __________________
- Amount: ____________________
- Other: ____________________

### Neurological
- Alert: ________________
- Confused: ________________
- Sedated: ________________
- Somnolent: ________________
- Other: ____________________
- Person: ________________
- Place: ________________
- Time: ________________
- Reaction: ________________
- Brisk: ________________
- Sluggish: ________________
- No Response: ________________
- Deviation:
- Size: ________________
- LOC: ________________
- Alert: ________________
- Confused: ________________
- Sedated: ________________
- Somnolent: ________________
- Other: ____________________

### Eyes
- Blurred Vision: ________________
- Double vision: ________________
- Inflammation: ________________
- Pain: ________________
- Color blind: ________________
- Itching: ________________
- Pupils abnormal: ________________
- Drainage -- Color: __________________
- Amount: ____________________
- Other: ____________________

### Ears
- HOH (R): ________________
- Deaf: ________________
- Tinnitus: ________________
- Sense of balance: ________________
- Pain: ________________
- Bleeding gums: ________________
- Lesions: ________________
- Sense of taste: ________________
- Place: ________________
- Pain: ________________
- Headaches: ________________
- Other: ____________________
- Person: ________________
- Non-productive: ________________
- Productive – Color: __________________
- Amount: ____________________
- Other: ____________________

### Nose
- Congestion: ________________
- Pain: ________________
- Sinus problems: ________________
- Bleeding gums: ________________
- Lesions: ________________
- Other: ____________________

### Mouth
- Halitosis: ________________
- Pain: ________________
- Bleeding gums: ________________
- Lesions: ________________
- Taste: ________________
- Other: ____________________

### Throat/Neck
- Sore throat: ________________
- Hoarseness: ________________
- Lumps: ________________
- Swollen glands: ________________
- Other: ____________________

### Other
- Other: ____________________
- Other: ____________________
Physical Findings: □ NSF

Describe and graph all abnormalities by number:

1. Bruises
2. Incisions
3. Lacerations
4. Rashes
5. Decubitus
6. Dryness
7. Scars
8. Lesions
9. Abnormal color
10. Other: ____________________________
11. Tattoos
12. Body Piercing
13. Skin Tear/ Duoderm/Op-Site

Gastrointestinal: □ NSF

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
<th>Date</th>
<th>Color</th>
<th>Type</th>
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<tbody>
<tr>
<td>Appetite</td>
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<td>Last BM</td>
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<tr>
<td>Laxative use – Type</td>
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<td>Yes</td>
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<td>No</td>
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<td>Constipation</td>
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<td>Yes</td>
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<td>No</td>
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<tr>
<td>Diarrhea</td>
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<td>Yes</td>
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<td>No</td>
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<td>Nausea</td>
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<td>Yes</td>
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<td>No</td>
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<tr>
<td>Vomiting</td>
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<td>Yes</td>
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<td>No</td>
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<tr>
<td>Bowel sounds</td>
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</table>

Appetite: Good

Recent change _____________________________

Last BM Date: _________ Color ___________________  Frequency: ___________________

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Laxative use – Type __________ Frequency ___________________

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Recent change _____________________________

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Last BM Date: _________ Color ___________________  Frequency: ___________________

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Laxative use – Type __________ Frequency ___________________

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Reproductive: □ NSF

FEMALE

LMP G P A: Last PAP: □ Yes □ No Birth control

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Vaginal discharge: □ Yes □ No Itching

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Menopausal – How long? □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Hx STD exposure: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Do SBE Monthly? □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Hematological: □ NSF

Bruising: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Amenorrhea: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Nipple discharge: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Hemoglobin: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Breast feeding: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Hx of calculi: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Hx UTI: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Hx of calculi: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Hx UTI: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Testicular lumps: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Blood Transfusion: □ Yes □ No

Yes                          |           |               |       |      |
No                           |           |               |       |      |

Nurse doing Assessment: Date: ____________________________
Advanced Directive

Does the patient have an Advanced Directive?  □ No □ Yes – Is copy on file?  □ No □ Yes – where?
Advanced Directive form on chart?  □ Yes □ No – explain
Additional information given?  □ Yes □ No – explain

After assessing the above data and interviewing the patient, the R.N. will complete the following:

The following Nursing care plans will be instituted:

_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

Patient would like further information regarding:
☐ Medication ☐ Exercise ☐ Mental Health Services ☐ Diet ☐ Smoking Cessation ☐ Weight Control ☐ Drug/Alcohol Abuse

The following educational needs have been identified and will require further follow-up: ____

_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

Patient’s / Family’s perceived discharge needs (ADLs, meals, etc.): ______________________

_______________________________________________________________
_______________________________________________________________
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_______________________________________________________________
_______________________________________________________________

Additional Comments:

_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

R.N. Signature:_______________________________________________________________

Date: ____________________________ Time:________________________