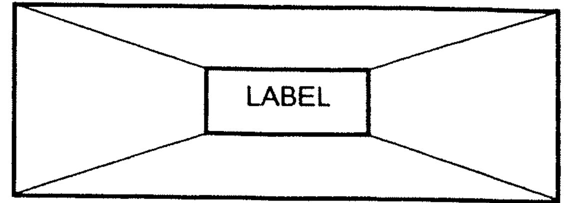
Muhlenberg Regional Medical Center

Interdisciplinary Admission History and Assessment

This page MUST be faxed to Pharmacy - No medications will be dispensed without allergy information, height and weight



A. ADMITTING DIAGNOSIS | Date: | Time: | Male / Female | Age | Primary Language: | Cyraphone #

Admission info obtained from:

Admitted From: Home ER JRI SDS
NH: Facility________
Sar: Facility ________ Days Left:________

Name of S/O, Guardian or Power of Attorney: **Relationship:** **Phone:** Home: Work: Cell:

Name of Contact Person: **Relationship:** **Phone:** Home: Work: Cell:

To Floor Via: Ambulatory / Wheelchair / Stretcher	**Pregnant:** Yes / No / N/A	**B/P:** RA LA / Thigh / R L	**Temp:** Oral / Rec / Axil	**Pulse:**	**Resp**	**Pulse Ox**

(Pt **MUST** be weighed on Admission)
Actual Weight:

Height:

Previous Blood Transfusion ☐ Yes ☐ No
Blood Donor: Patient Family

Why are you being admitted to the Hospital?
Patient understanding of current condition/hospitalization.
Medication Information received from: Patient Family Member Transfer Sheet Significant Other MD

B. CURRENT MEDICATIONS	**DOSE**	**HOW OFTEN**	**LAST TAKEN**	**REASON FOR TAKING**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
Do you Use Complimentary or Alternative Medications?				
List: 1.				
2.				

RECENT IMMUNIZATIONS **Flu** **Pneumonia** **Tetanus** **Hepatitis** **Other**
Please indicate date ______ ______ ______ ______ ______

C. ALLERGY AND MEDICATION INTOLERANCES:
Do you have any Food, Drug, Latex, Rubber or Environmental Allergies? Yes No
Any allergy to Dyes or Contrast Media? Yes No

Please list Allergies:	**Symptom**	**Severity**
	Indicate letter and number from scale →	
1.		
2.		
3.		
4.		
5.		
6.		

Symptom	**Severity**
a. Difficulty breathing **b.** Swollen tongue, lips **c.** Drop in blood pressure **d.** Blood dyscrasia, anemia, thrombocytopenia **e.** Seizures, fainting	**1** Severe
f. Severe rash/skin reaction **g.** Severe GI symptoms	**2** Moderate
h. Itch **i.** Diarrhea **j.** GI upset/heartburn **k.** Nausea and/or vomiting **l.** Dizziness, drowsiness	**3** Mild
m. Does not remember **n.** Other (Description necessary)	**4** Unknown

Patients with allergies require a red allergy band placed on wrist.
Allergy Band On ☐ *Correct Patient ID band on Patient* ☐

R.N. Signature ________________

D. LATEX ALLERGY SCREENING TOOL:

1. Have you ever had an allergic reaction to latex or rubber devices? Yes No

   If yes, please explain ______________________________

2. Do you have any condition that has required multiple surgeries, such as spina bifida, meningomycele, or a congenital urologic anomaly? Yes No

   If yes, please explain ______________________________

3. Have you ever had swelling, itching or hives on your lips or around your mouth after blowing up a balloon? Yes No

4. Have you ever had swelling, itching or hives after being examined by someone using latex gloves, such as a Dental or GYN exam? Yes No

A *Yes* to *ANY* of the above questions indicates that this patient may have a high risk for latex allergy and the Latex Allergy Precaution Protocol must be implemented. The attending physician must also be notified.

E. ADVANCE DIRECTIVES

Do you have an Advance Directive? Yes No

If Yes: Have you brought a copy? Yes No

If No: Would you like information? Yes No

(* Give info and offer assistance from the Pt. Rep if needed)

Were there any changes made on your Advance Directive since your last admission? (*Document changes below) Yes No

* Do you wish to view the Advance Directive video on the Patient Education Channel? Yes No

Documentation of changes to Advance Directive: ______________________________

F. HEALTH HISTORY

	PT	Fam		PT	Fam		PT	Fam		PT	Fam
Heart Disease			Cancer			Gasrointestinal Disease			GU Problems		
Diabetes			HIV			Seizures			Lung Disease		
Stroke			Hepatitis			High Blood Pressure			Psych Disorders		
TB											

Other (explain): ______________________________

Date	Previous Hospitalization	Reason	Treatment

Alcohol Use: Yes No Type and amount __________ Last Taken __________

Substance Use: Yes No Type and amount __________ Last Taken __________

Tobacco Use: *Yes No Type and amount __________ Last Taken __________

IV Drug Use: Yes No Type and amount __________ Last Taken __________

*** Must be entered on Teaching sheet and Discharge Instructions**

G. FALL RISK SCREENING:

G. FALL RISK SCREENING:	SCORE		NUMBER OF POINTS
HISTORY OF FALLS On admission, have you fallen within the last three months?	Yes	No	2
COGNITIVE IMPAIRMENT: *(nurse's observation)* a. Impaired judgement, and/or lack of safety awareness	Yes	No	3
b. Agitation-definition: excessive motor activity, nonpurposeful & associated with internal tension. E.g. fidgeting, pacing, pulling at clothes.	Yes	No	2
ALTERED ELIMINATION: Do you ever wet or soil yourself on the way to the bathroom?	Yes	No	1
DIZZINESS/VERTIGO: Do you ever experience dizziness or vertigo?	Yes	No	1
IMMOBILITY: Does patient have impaired gait, shuffle/wide base or unsteady walk?	Yes	No	1
Score of 2 or greater or a fall while hospitalized should initiate Fall Prevention Protocol and be included on the problem list.	Yes	No	Total Score: ____

RN Signature: ______________________ LPN Signature: ______________________

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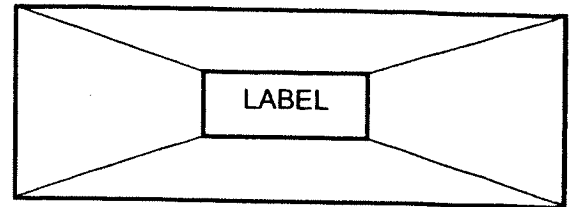


H. Pain Assessment

Do you have pain now? Yes No

Have you had pain in the last 6 months? Yes No

Location:____

Quality: Use patients own words: Aching Throbbing Burning Dull Sharp Stabbing
other:____

Onset, Duration Variations, Patterns:

Is there anything that contributes to the onset of your pain?____________________________

How long does the pain episode last? ____

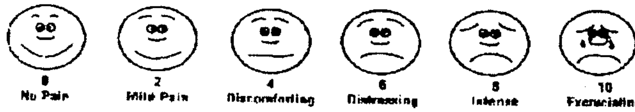
What makes it worse?____

Medications: List all medications you take at home for pain:________________________________

Are you satisfied with their pain relief effect? i.e. Do the medications help you? Yes No

Do you use alternative medicine techniques? Yes No Music Guided Imagery Therapeutic Touch Stress Reduction

Pain Assessment Ruler



Intensity: (Δ scale) ____________
0=none 10=greatest

Effects Of Pain-Does pain interfere with any of the following functions:

Relationships with others Sleep Appetite Emotions Daily Activities No impact on function

Patient's GOAL for Pain Management during hospitalization: (0 – 10) __________

Comments:____

I. PSYCHOSOCIAL ASSESSMENT: *Social Work Screen ** Pastoral Care Consult

Marital Status: Married Single Widowed Divorced Separated

Type of Housing: Apartment House Senior Housing *Nursing Home *Boarding Home *Assisted Living
One-Level Multi-Level Stairs/Bathroom availability Independent *Needs Assistance

Living Arrangements: Lives with____ *No Family/SO
Lives alone/Local support: Explain______________________________________ *Lives alone/No support

Would you like to be visited by the Hospital Chaplain? **Yes No

Visited by your own Religious leader? Yes No If yes, Name____________________________Phone______________

Do you have any religious or cultural needs related to your care? (i.e. diet, Blood transfusions, religious practices)____________

What are your/your significant others fears, anxieties or concerns related to this hospitalization now?________________

Are you a caregiver for someone? * Yes No If yes, Whom?____

Describe your support system: Family Friends Other Community Programs Explain_____________________

Interests, Activities, Hobbies:____

Behavior: Relaxed/Calm ***Anxious ***Depressed *** Suspicious Other: ____________

***Current counseling/coping assistance:____

Will someone be able to assist you (if needed) when you return home? Yes *No If yes, Whom______________________
____phone:______________________

Elopement Assessment

1. Is substance abuse an active issue that could cause an immediate danger to self or others? Yes No
2. Is the patient cognitively impaired? Yes No
3. Is the patient currently a danger to self or others? Yes No
4. Is the patient currently (or in the process of being) committed to a psychiatric institution? Yes No

*If yes to any of the aforementioned questions: complete the **Elopement Risk Assessment Tool**.*

VICTIMS OF ABUSE: *Social Work Consult

* Presence of unexplained and/or treated bruises. *Yes None Observed
* Chronic pain with no physical evidence. *Yes None Observed
* Fearful for returning home for safety (crying and/or depressed) *Yes None Observed

How do you react when you become overwhelmed by feelings of sadness, frustration, disappointment or anger?
Please explain: ____

* Other: Explain ____

RN Signature: ____

J. EDUCATIONAL NEEDS ASSESSMENT:

How do you prefer to learn? Read Verbal Pt/Family readiness to learn: Yes No Explain:____________

Barriers to learning are identified on admission: *None* *Language *Cultural *Religious *Emotional *Physical *Cognitive

Other:____

***Any barriers to communication, please Implement Communication Assessment Tool**

K. FUNCTIONAL ASSESSMENT:

Key: I=Independent A= Assistance Needed D=Dependent *Changes in activity level require Screening Consult

NEUROLOGICAL		ORTHOPEDIC		MEDICAL
CVA / TIA	Spinal Cord Injury	LE Fx Including Pelvis	UPPER EXTREMITY	Cardiac
Traumatic Brain Injury	Parkinson's Disease	Restricted Weight Bearing	Involvement	Pulmonary
Craniotomy	Balance Disorder	Compression Fracture	___Dominant Hand	Acute mental status change
Guillian Barre'	Dysphagia	Multiple Trauma	___ Bilateral	Rheumatoid Arthritis
Acute MS	Laryngectomy	Total Joint Replacement		Visual Impairment
Other ________	Alzheimers	Acute Amputation		Other ________
		Other ________		
☐ No Referral Necessary		☐ No Referral Necessary		☐ No Referral Necessary

ACTIVITY	Prior	Current	Referral Requested	ACTIVITY	Prior	Current	Referral Requested
Eating			OT	Transfer – Bed/ Chair/Wheelchair			PT
Grooming			OT	Balance			PT
Bathing			OT	Ambulation			PT
Dressing			OT	W/C, Cane, Walker			PT
Toileting			OT	Safety Awareness / Risk of Falls			PT
Bladder Management			NSG	Verbal Expression			SP
Bowel Management			NSG	Swallowing			SP
Tub, Shower, Toilet: Assistive Device			OT	Wet / Voice / Drooling / Coughing			SP

L. PROSTHETICS/ORTHOTICS/DURABLE MEDICAL EQUIPMENT

1) Pacemaker Type:____________________ Date Inserted:____________________

2) Trach: Type: Shiley Metal Date Inserted:____________________

a) Date last Changed____________________

3) Central Venous Access Device: PICC Port Pasport Aphresis

a) Date Inserted____________________ Date Changed____________________

b) Location:____________________

c) Needle Size: ____________________

4) Catheters: Foley Size____________ S/P Tube Size____________

a) G Tube J-Tube NGT

b) Date Inserted____________________ Date Changed____________________

c) Feeding Formula____________________

5) Hemo Access: AVF R L Graft R L

a) Perm Cath SVC JUG Tenckhoff (PD Catheter)

b) Date Inserted____________________ Date Changed:____________________

c) Dialysis Center____________________

d) Dialysis Days:____________________

6) Ventilator Settings____________________

7) BiPap/CPAP Settings____________________

8) Nebulizer: Meds/Frequency____________________

9) Home 02 ____________________

	Y	N	With PT
Hearing Aid			
Dentures-Upper			
Dentures-Lower			
Eyeglasses			
Contact Lenses			
Cane			
Crutches			
Prosthesis			
Brace/Splint			
Walker			
Wheelchair			
Glucometer			

M. ANESTHESIA ASSESSMENT:

Have you ever had general anesthesia? Yes No If yes, explain____________________

Have you or a member of your family ever had a "bad" reaction to general anesthesia? Yes No If yes, explain____________

RN Signature:

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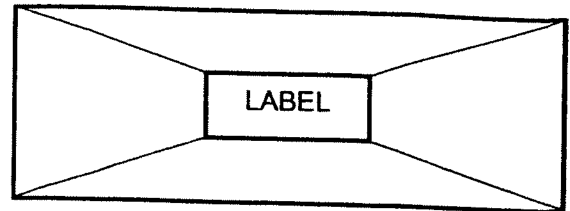


N. PHYSICAL ASSESSMENT

Sensory / Perceptual – Assess eyes, ears, nose, throat ☐ No Problem

Impaired vision	blind	pain	reddened	drainage	gums	taste	Adaptive:language
Hard of hearing	deaf	burning	edema	lesion	teeth	smell	other

Explain:

Respiratory – Assess chest configuration, respiratory rate, rhythm, depth, pattern, comfort SaO2 & Peak Expiratory Flow Rate ☐ No Problem

asymetric	Tachypnea > 20	Sleep apnea	Cracles	Cough	Absent breath sounds
other	Barrel chest	Bradypnea < 8	Shallow	SOB	Expectoration(color)
Diminished	O2 sat. < 90%	Dyspnea	Orthopnea	Labored	Wheezing
Pain	Cyanotic	Peak expiratory flow < 200			

Explain:

CARDIOVASCULAR - Assess rate, rhythm, pulse, circulation, fluid retention, comfort ☐ No Problem

Irregular	Tachycardia	Fatigue	Numbness	Diminished pulses	Edema	Risk of DVT
Pain	Bradycardia	Palpitations	Tingling	Absent pulses	JVD	Other

Explain

GASTROINTESTINAL - Assess abdomen, swallowing, bowel sounds, comfort ☐ No Problem

Diet: Bowel Habits: Bowel Incontinence:

Wt. Loss > 10% in 6 mos.	Thirst	Hemodialysis	Distention	Hyperactive BS
Wt. Loss > 5% in Past month	Laxatives	Pregnancy	Rigidity	Mass (type)
Wt. Gain	Parenteral Nutrition	Diarrhea	Flatulence	Emaciated
Inability to eat prior to Adm.	Anorexia	Constipation	Peridontal/chewing problems	Other
Tube Feeding	Dysphagia	Hemorroids	Breast Feeding	
nausea or vomiting	Pain	Strictures	Hypoactive BS	

Explain:

NEUROLOGICAL - Assess motor function, sensation, LOC, strength, grip, gait, coordination, orientation, speech, pupils. ☐ No Problem

Weakness	Numbness	Headaches	Paralysis	Stuporous	Vision	Grip
Unsteady	Tingling	Seizures	Lethargic	Comatose	Pupils	Hx of Falls
Vertigo	Pain	Tremors	Confused	Syncope	Speech	Other

Explain

GENITOURINARY- Assess urine freq., control, color, consistency, odor. GYN: Assess bleeding, discharge, pregnancy, breasts. ☐ No Problem

Last menses' Last PAP smear: Last Breast Exam / Mammography Contraception

Pain	Urgency	Oliguria	Hematuria	Infection	Pregnancy	Rhogam
Frequency	Urinary Incontinence	Nocturia	Urine Color	Discharge	Para	Lactation
Hesitancy	Burning	Dysuria	Catheter	Vag. Bleed	Gravida	Other

Explain:

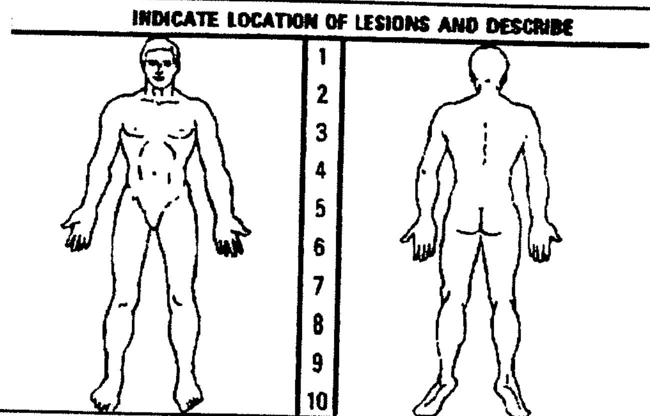
MUSCULOSKELETAL / INTEGUMENTARY SYSTEM - ☐ No Problem
Assess mobility, motion, gait, joint, skin integrity, hair and nails.

Stiffness	Lesion	Decubitus	Nails
Swelling	Rash	Scaly	Other
Wound	Ecchymosis	Hair Loss	Contractures
Pain	Drainage	Hair Growth	

Explain and / or describe by site number:

Identify site with 0 and draw a line from number to site.

INDICATE LOCATION OF LESIONS AND DESCRIBE



STAGING CLASSIFICATION
1. Redness / discoloration. Skin intact.
2. Skin broken. Healthy tissue present, usually superficial.
3. Tissue necrotic, sealed or open.
4. Wound depth with necrosis.

SKIN INTEGRITY NORTON RISK ASSESSMENT TOOL – Assess the potential for skin breakdown.

Score: ☐ No Problem High Risk for Skin Breakdown (Score 14 or less)

Physical Condition		Mental Condition		Activity		Mobility		Incontinent (Bowel and / or Bladder)	
Good	4	Alert	4	Ambulatory	4	Full	4	Not	4
Fair	3	Apathetic	3	Walk / Help	3	Slightly Limited	3	Occasional	3
Poor	2	Confused	2	Chairbound	2	Very Limited	2	(< 2 per 24 hours)	2
Very Bad	1	Stupor	1	Bed	1	Immobile	1	Always	1

Explain:

☐ Initiate Skin Care Flowsheet for All pts.

☐ Initiate Nursing Intervention Sheet, and Physician Order Form for high risk pts.

O. OTHER:

Oriented to room? Yes No Patient Health Journal reviewed? Yes No Correct ID Band is on Patient Yes No

Oriented to call bell? Yes No

Provision made if unable to press call bell? If so, what provision?________________________________

Physician notified of admission? Yes No

Which Physician?________________________________

Time: ____________________ Date: ____________________

By whom?________________________________

RN Signature:________________________________

BED ENTRAPMENT RISK ASSESSMENT: *Identification of the vulnerable patient*

Acknowledgement of one or more of the below indicates At Risk for Bed Entrapment.

	Frail (small framed, slight build)		Delirium		Restraints
	Confused		Restlessness, sleeping problems		Mattress / side rail gap noted
	Agitated		Uncontrolled body movement / lack of muscle tone		
	Disoriented		Mediations that alter mental status		
	Memory problems		CVA with residual weakness		

Patient at risk for Bed Entrapment? Yes No

If Yes, document in problem list below.

P. PROBLEM LIST:

Problem Number	Date Entered	List significant Acute and Chronic Conditions	Active	Potential
1.				
2.				
3.				
4.				
5.				
6.				

NURSE'S SUMMARY NARRATIVE ASSESSMENT

R.N. Signature ________________________________