ADMISSION ASSESSMENT AND HISTORY – DAY/NIGHT CARE: MEDICINE

Admission Date/Time:

Language spoken/understood: ☐ Translator required ☐ En ☐Fr ☐ Other: | **Age**

Diagnosis:

Procedure and Date Booked: | ☐ **Consult** ☐ **Consent** on pt record

Key Contact: *(name, relationship, ph#)*

Legal Substitute Health Care Decision Maker: ☐ as above
☐Proxy ☐ Personal Guardian ☐Nearest relative
(name, relationship, ph#) Copy of documents ☐ Proxy ☐ Personal Guardian

Advance Care Plan (Health Care Directives): ☐ Yes ☐ No ☐ on file
Location:

Allergies: *(describe reaction(s))* ☐ None Known
☐ Medi Alert on ☐ Agency Alert on
☐ Facility specific Allergy/Intolerance record completed *(if applicable)*
☐ Drug:
☐ Food:
☐ Latex:
☐ Environment:

Test(s)/X-ray(s) completed to date: ☐ **On Record** ☐ CBC ☐ Electrolytes ☐ UA ☐ CXR ☐ ECG ☐ Crossmatch ☐ Other:

		Yes	No	
PH	**Personal care assistance**			
PH	**Devices brought**			Dentures: ☐ U ☐ L ☐ Loose teeth ☐ Glasses ☐ Contact lens Hearing aid: ☐ Rt ☐ Lt
ELIM	**Bowel problems**			☐ Incontinent Date of last BM:
ELIM	**Bladder problems**			☐ Incontinent ☐ Catheter *(type, size)*
NUTR	**Feeding assistance**			Diet: ☐ Reg ☐ Other:
NUTR				☐ NPO Last ate: Last drank:
MOB	**Ambulation assistance**			
MOB	**Devices brought**			☐ Cane ☐ Walker ☐ Wheelchair ☐ Prosthesis *(list)* ☐ See Mobility Record

OBSERVATIONS AND MEASUREMENTS

T °C	**P**(per min)	**R**(per min)	**BP** (mmHg)	**SaO_2 %**	**Apical Pulse**	**Pedal Pulse(s)** (Rt) (Lt)	**Wt**(kg)	**Ht** (cm)	**LMP** ☐ NA

Pain ☐Unable to verbalize pain
Provoked by:
Quality: ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Crushing ☐Intermittent ☐Occasional ☐Other:
Radiates/ Location:
Severity: 0 1 2 3 4 5 6 7 8 9 10
Time (when it started, how long it lasts):

Systems Assessment *(CNS, CVS, Resp., GI, GUR, MS, Integ, EENT)* ☐ See Assessment Addendum – Ambulatory

History pertinent to this admission *(include previous surgery/anesthesia/reactions)*

History of ARO: ☐ Not Known ☐ No ☐ Yes *(list)* ☐ **Facility ARO screening tool completed** (if applicable)

Exposure to:	**Yes**	**No**
HIV		
Hepatitis		
TB		
Other:		

Comments:

MEDS **Current Medications:** ☐ NA ☐ See Best Possible Medication History (BPMH)

MEDS **Pharmacy of Choice** *(Name and Location):*

		Yes	No	
TX PRO	**Previous blood transfusion(s)** *(describe reactions, if any)*			
TX PRO	**Present treatments**			☐ Home Care ☐ O2 ☐ Physiotherapy ☐ Chiropractor ☐ Massage Therapy ☐ Complementary Therapies: (describe) ☐ Other:
TE	**Learning needs**			
S	**Safety needs**			☐ Facility-specific falls risk assessment completed
PS	**Assistance available on discharge**			Name/Phone #:
PS	**Alcohol use in last 24 hours** *(If yes, when and how much?)*			
PS	**Smoker** *(# per day)*			
PS	**Illicit drugs used** *(describe)*			
PS	**Mental, emotional, behavioural status**			

Valuables: ☐ Locked ☐ At bedside | **Orientation to: ☐ Layout ☐ Routine** | **ID**

INDIVIDUAL CARE PLAN – DAY/NIGHT CARE: MEDICINE

Date _____

	INITIATOR	DESIRED OUTCOME	Outcome Met / ID	Time Init'd / ID	INTERVENTIONS	Time disc / ID
PERSONAL HYGIENE	self care deficit	Resumes self care			Assist with	
	r/t					
					Self care	
ELIMINATION						
					Self care	
NUTRITION					Diet as tolerated	
					Self feed	
MOBILITY						
					Self mobility	
OBS AND MEAS	R/f altered vital signs r/t	Early detection of deviations			Vital signs	
					BP	
	R/f altered fluid balance r/t	Early detection of deviations			I and O	
MEDS					See Med record	
					See IV record	
TX AND PRO	Impaired skin integrity r/t	Early detection of complications			Dressing	
TEACHING	Knowledge deficit r/t	Verbalizes understanding of			Explain diagnostic tests, procedures	
SAFETY	R/f injury r/t	No injury				
PSYCHOSOCIAL	Anxiety r/t surgical procedure	Verbalization of ↓ feelings of			Keep pt/significant other informed and	
		anxiety			encourage verbalization of feelings	

RECORD OF CARE – DAY/NIGHT CARE: MEDICINE

VITAL SIGNS

DATE

TIME / / / / / / / / / / / / / /

230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

BP ^ v

P ●

Temp

Resp

SpO_2

Pain *(0-10)*

ID

INTAKE AND OUTPUT RECORD

TIME	ORAL	EMESIS	URINE	DRAINAGE	OTHER	ID

IV FLUIDS

TIME	IV SOLUTION / AMOUNT (mLs)	RATE (per min)	ADDITIVES	NEEDLE SIZE / TYPE / SITE	AMT ABSORBED (mLs)	COMMENTS	ID
				IV Total			

MEDICATIONS

TIME	MEDICATION	DOSE	ROUTE	FREQ	COMMENTS	ID

NOTES AND NEEDS ASSESSMENT – DAY/NIGHT CARE: MEDICINE

DATE	TIME	COMP	NOTES

NEEDS ASSESSMENT

	N	D	E		N	D	E
Obtain baseline data	4	4	4	IV/ Blood products	1	1	1
Hygiene/Skin/Oral	2	2	2	Respiratory treatment	1	1	1
Undress/Dress	1	1	1	Suctioning	2	2	2
Bowel management	1	1	1	Tubes	1	1	1
Bladder management	1	1	1	Skin/Wound *(prep/care)*	1	1	1
Mobility : assist	2	2	2	Specimen collection	1	1	1
: restricted	1	1	1	Special procedures	2	2	2
Monitor feeding	1	1	1	Teaching *(pt/significant other)*	1	1	1
NPO	1	1	1	Safety measures	.5	.5	.5
Assess : q2h or ↓	1	1	1	Emotional *(pt/significant other)*	1	1	1
: q1h or ↑	2	2	2	Behaviour mgmt *(pt/significant other)*	1	1	1
Intake and Output	1	1	1	Communication difficulties	1	1	1
Medication(s)	.5	.5	.5				
Totals (a)				**Totals (b)**			
				Totals (a) and (b)			
				Category			
				ID			

Category	Points
1	1-7
2	8-14
3	15-21
4	22 or more

DISCHARGE CRITERIA

	Yes	No	NA	Comments
Alert/Oriented				
Voided				
Ambulated				
Diet/fluids tolerated				
Vital Signs stable				
Pain controlled				
Drsg dry and intact				
Rx given				
Meds returned				

Date/Time of Discharge:

Accompanied by:

ID