ADMISSION ASSESSMENT AND HISTORY
MEDICINE/SURGERY

Pre–Admission – Date/Time ☐ See Notes	☐**Verification of patient ID band** **Admission – Date/Time** **Reviewed and completed by:** ☐ See Notes
Language(s) Spoken: ☐ En ☐ Fr ☐ Other: ☐ Translator required	**Occupation / Education**

Source of Information ☐ Self ☐ Other: | **Age**

Diagnosis/Procedure
Date Booked:

☐ **Consult**
☐ **Consent**
on pt record

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

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

Key Contact: ***(name, relationship, tel # s)***

Legal Substitute Health Care Decision Maker ☐ Proxy ☐ Personal Guardian ☐ Nearest relative Copy of docs: ☐ Proxy ☐ Personal Guardian
(name, relationship, tel # s)

Advance Care Plan (Health Care Directives): ☐ Yes ☐ No ☐ On file Location of form:

Other contacts: *(name, relationship, phone #'s)* 1.

2.

Financial Power of Attorney:

	Questions		Yes	No	Patient's Response and Interviewers Comments
PERSONAL HYGIENE	**Personal care assistance** *(describe specific routines)*	**bathing**			☐ Tub ☐ Shower ☐ Other: ☐ Pre-op bath done
		grooming			
		oral care			
		dressing			
		assistance provided			☐ Family ☐ Home Care ☐ LTC ☐ Day Care
	devices used by patient				Hearing aid(es) ☐ Rt ☐ Lt Denture(s) ☐ Upper ☐ Lower ☐ Partial ☐ With Patient ☐ At Home ☐ Glasses ☐ Contact lens ☐ Other:
ELIMINATION	**Difficulty with bowel care** *(describe problem and help needed)*				☐ Constipation ☐ Diarrhea ☐ Incontinence Aids used: ☐ Laxative use*(what and how often)* ☐ Pads ☐ Other: ☐ Liners Bowel Pattern: ☐ daily ☐ EOD ☐ q 3 days ☐ Briefs/Pull-ups ☐ Other: ☐ Other: Date of last BM:
	Difficulty with bladder care *(describe problem and help needed)*				☐ Incontinence ☐ Indwelling Catheter*(size/ type)* Aids used: ☐ Frequency*(how often)* ☐ Pads ☐ Nocturia*(# of times up)* Freq. of change: q ☐ Liners Toileting regime: ☐ Intermittent catheter q ☐ Briefs/Pull-ups Date of last change: ☐ Other:
NUTRITION	**Specific diet** *(specify)*				☐ Regular ☐ Other: Nutritional Pattern: ☐ 3 regular meals ☐ 6 small meals ☐ hs snack ☐ between meal snacks ☐ Other:
	Malnutrition screening *Two 'YES' answers, consult dietitian. Date:*				Have you lost weight in the past 6 months without trying to lose this weight? ☐ Yes ☐ No *(If a patient reports a weight loss but gained it back, consider it as 'NO' weight loss.)* Have you been eating less than usual for more than a week? ☐ Yes ☐ No
	Food intolerance *(specify)* **Difficulty eating/drinking**				☐ Difficulty chewing ☐ Dysphagia ☐ Recent weight gain ☐Recent weight loss ☐ NPO ☐ Last ate: ☐ Last drank:
MOBILITY	**Physical disabilities** *(describe help needed)*				☐ See TLR Assessment/ Mobility Record
	Devices used				☐ Walker ☐ Prosthesis: *(list)* ☐ With Patient ☐ Cane ☐ Orthopedic: *(list)* ☐ At Home ☐ Wheelchair ☐ Other:

OBSERVATIONS AND MEASUREMENTS

Temp. °C	Pulse	Resp./ min.	Blood Pressure	SpO_2 %	Blood Glucose mmol/L	Apical Pulse	Pedal Pulse (R)	Weight	Height
°C				%	mmol/L		(L)	kg	cm

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):

NORMAL FINDINGS	ABNORMAL SIGNS	HISTORY/CURRENT MEDICAL CONDITIONS	COMMENTS
CNS ☐	☐ Tremors ☐ Pupils unequal ☐ Dizziness ☐ Speech slurred ☐ Vertigo ☐ Paraplegia ☐ Unsteadiness ☐ Quadriplegia ☐ Disoriented ☐ Hemiplegia ☐ Memory loss ☐ Hemiparesis ☐ Headache ☐ Motor/Sensory loss	☐ Seizure disorder ☐ Traumatic brain injury ☐ Stroke ☐ Parkinson's disease ☐ TIA ☐ Migraine headaches ☐ Cerebral palsy ☐ Headaches ☐ Multiple Sclerosis ☐ Depression ☐ Alzheimer's ☐ Panic Attacks ☐ Other dementia ☐Diabetic Neuropathy	☐ Other: ☐ Confusion Assessment Method completed
CVS ☐	☐ Heart murmur ☐ Arrhythmia ☐ Cyanosis ☐ Tachycardia ☐ Edema ☐ Bradycardia	☐ CHF ☐ MI ☐ Hypertension ☐ Angina/Chest pain ☐ Hypotension ☐ Cardiac dysrhythmia ☐ Anemia ☐ ASHD ☐ Blood disorder ☐ VTE ☐ Rheumatic fever ☐ PVD ☐ Syncope ☐ Varicose Veins	☐ Pacemaker ☐ Implanted cardioverter/defibrillator ☐ Other:
Resp ☐	☐ Shallow ☐ Wheezing ☐ Rapid ☐ Cough ☐ Slow ☐ SOB ☐ Dyspnea	☐ Asthma ☐ Frequent URI ☐ Pneumonia ☐ COPD ☐ Bronchitis ☐ Emphysema ☐ Sleep Apnea ☐ TB	☐ Chest sounds clear ☐ Uses CPAP/BiPAP ☐ Other:
	Obstructive Sleep Apnea Screening (for pre-surgical patients only) ☐NA ☐ **S** Snore loudly - heard through closed doors; bed-partner elbows you for snoring? ☐ **T** Tired – feel tired, fatigued, sleepy during daytime (fall asleep while talking)? ☐ **O** Observed to stop breathing or choking/gasping when sleeping? ☐ **P** Do you have or are you being treated for high blood pressure?	***If high risk, Anesthesia notified: Dr.**_____ *Time:*_____ ☐ **B** is the BMI over 35 kg/m²? ☐ **A** is the patient over 50 years? ☐ **N** is the neck girth over 40 cm (Female -16in; Male -17in)? ☐ **G** is the patient male?	☐ *High risk – 3 or more ☐ Low risk – 2 or less
GI ☐	☐ Flatulence ☐ Diarrhea ☐ Constipation ☐ Distension ☐ Nausea ☐ Lump ☐ Emesis ☐ Obesity ☐ Indigestion ☐ Asymmetry ☐ Heartburn	☐ Bulimia ☐ Cholelithiasis ☐ Hiatus hernia ☐ Anorexia ☐ Umbilical hernia ☐ Stomach pain ☐Gastroparesis ☐ Ulcer ☐Celiac ☐ Hemorrhoids	☐ See Elimination ☐ Bowel sounds normal x 4 quadrants ☐ Other:
GUR ☐	☐ Discharge ☐ Blood in urine ☐ Burning ☐ Lesions	☐ Cystocele ☐ Menstrual problems ☐ Rectocele ☐ Hysterectomy ☐ Kidney problems ☐ Frequent UTI ☐ Renal failure ☐ Prostate problems ☐ Sexually Transmitted Infection	☐ See Elimination LMP *(date)* ☐ NA Pregnant ☐ Yes ☐ No T___ P___ A___ L___G___
Integ ☐	☐ Bruising ☐ Rash ☐ Dry ☐ Lesions ☐ Pale ☐ Diaphoretic ☐ Abrasions ☐ Flushed ☐ Dehydrated ☐ Ulcer ☐ Jaundice ☐ Oily ☐ Pruritus ☐ Cyanosis ☐ Lumps	☐ Psoriasis ☐ Bruises easily ☐ Herpes zoster ☐ Tattoos ☐ Herpes simplex ☐ Piercings ☐ Eczema	☐ Facility-specific pressure sore risk tool completed ☐ See Wound Record ☐ Other:
MS ☐	☐ Swelling ☐ Limited ROM ☐ Deformities ☐ Spasms ☐ Weakness/Atrophy ☐ Amputation(s)	☐ Osteoporosis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Scoliosis ☐ Gout ☐ Back problems/pain ☐ Pathological fracture: ☐ Hip fracture (*last 6 months*): ☐ Rt ☐ Lt ☐ Other fracture (*last 6 months*):	☐ Other:
EENT ☐	☐ Deafness ☐ Facial paralysis ☐ Hoarseness ☐ Aphasia ☐ Blurred vision ☐ Discharge ☐ Nystagmus ☐ Conjunctivitis ☐ Tracheotomy	☐ Diabetic retinopathy ☐ Hearing problems ☐ Macular degeneration ☐ Sinusitis ☐ Glaucoma ☐ Tinnitus ☐ Cataracts	☐ Other:
ENDO ☐	☐ Exophthalmia ☐ Polydipsia ☐ Enlarged tongue ☐ Polyphagia ☐ Goiter ☐ Polyuria ☐ Glucosuria	☐ Hyperthyroidism ☐Prediabetic ☐ Hypothyroidism ☐Diabetes Mellitus Type 1 ☐Addison's Disease ☐Diabetes Mellitus Type 2 ☐Cushing's Disease	☐ Insulin pump ☐ Other:

ADMISSION ASSESSMENT AND HISTORY
MEDICINE/SURGERY

OBSERVATIONS AND MEASUREMENTS

Exposure to:	Yes	No	Comments
HIV			
Hepatitis			
TB			
Other:			

☐ **Facility ARO screening tool completed** (if completed then this section can be omitted)

Treated for AROs:			
VRE			
MRSA			
Other:			

Date of last influenza immunization: | **Date of pneumococcal vaccine:**

Date of last TB test and results:

Admitted in this province within the past 6 months: ☐ Yes ☐ No | **Admitted out of province within the past 12 months:** ☐ Yes ☐ No

Date of last hospitalization: | **Where:** | **Why:**

Patient's description of present condition

Patient's expectation of stay: | **Expected length of stay:**

History pertinent to this admission: *(medical, surgical, trauma, etc. and dates)*

☐ **Facility VTE screening tool completed** (if applicable according to facility specific policy)

MEDICATIONS

Current Medications/Herbals ☐ See Best Possible Medication History (BPMH)

Pharmacy of Choice *(Name and Location):*

	Yes	No	
IV/Parenteral therapy			
Previous anesthesia/intubation *(when and describe)*			
adverse reactions			

TX AND PRO

Previous blood transfusions *(when and why)*			
adverse reactions			
Presently receiving any treatment(s) *(describe, including discipline(s) providing care)*			☐ O_2 ☐ Trach care ☐ Ventilator ☐ ROM ☐ Ostomy care ☐ Skin/Wound care: *(specify)* ☐ Foot care: *(specify)* ☐ Pain therapy: *(list)* ☐ Complementary therapies: *(list)* ☐ Other:

Therapies
☐ Physiotherapy
☐ Occupational therapy
☐ Respiratory therapy
☐ Recreational therapy
☐ Chiropractic
☐ Other:

TEACHING

Assessment of patient/family understanding of condition(s), procedure(s) and related learning needs

SAFETY

Safety concerns ☐ Universal S.A.F.E. Precautions

1. In the past year, have you ever had any fall, including a slip or trip, in which you lost your balance and landed on the floor, ground, or lower level? ☐ Yes ☐ No

a. Has medical attention been sought due to a fall? ☐ Yes ☐ No

2. Does the patient have any identifying gait, balance, and/or mobility difficulties? ☐ Yes ☐ No

3. Using clinical judgement, is this patient at risk of falling based on presenting symptoms? ☐ Yes ☐ No

(Consider certain factors such as evolving illness (e.g. emerging delirium, impaired mobility, or new medications being prescribed), unfamiliar surroundings, acquired knowledge, other observations and assessments. If 'yes' to any of the questions, a comprehensive Fall Risk Assessment (e.g. Morse) must be completed along with care plan interventions.) ☐ Facility-specific falls risk assessment completed

☐ History of wandering:

PSYCHOSOCIAL

	Yes	No	
Personal/home/work concerns			☐ Lives alone, in own home ☐ With spouse/family ☐ Other housing (specify): ☐ Attends Day Program ☐ Home Care ☐ Time off from work ☐ No telephone ☐ No running H_2O ☐ No drinkable H_2O supply ☐ No indoor plumbing ☐Other concerns:
Family/friends/agencies for support **Now**			☐ Will visit ☐ Will bring in supplies ☐ Counselors: *(list)*
On Discharge			☐ Access to transportation ☐ Someone to check on patient ☐ Home care needed ☐ Counseling follow up
Religious/Ethnic aspects affecting care			
Clergy visit			Affiliation:
Substance use: *(describe when, why)* **Alcohol**			☐ Within last 24 hours? *(how much)*
Tobacco			☐ Smoked within last 6 months. Would you like information/assistance to quit? ☐ Yes ☐ No ☐ Smoking policy explained
Illicit Drugs			
Other			
Difficulty sleeping at night *(why and what helps?)*			☐ Trouble getting to sleep ☐ Frequent waking *(how often)* ☐ Recent changes in sleep pattern ☐ Pain ☐ Other: Sleep Pattern: Time to bed: Time waking: Daytime naps: ☐ AM ☐ PM

Assessment of patient's emotional status
(mood, thinking, behaviour)

☐ Facility-specific depression screening completed

Additional comments

Waiting for Long Term Care Placement: ☐ No ☐ Yes *(if yes, describe)*

Orientation to Unit:	**Yes**	**No**	**Disposition of belongings:** ☐ At bedside ☐ Taken home ☐ Locked up	**Date/Time:**
Physical layout			☐ See facility-specific patient belongings form ☐ Other:	ID(s):
Daily routine				**Date/Time:**
If No, why not:				**ID(s):**