ADMISSION ASSESSMENT AND HISTORY REHABILITATION

Admission – Date/Time	**Mode of Arrival to Unit** ☐ Walking ☐ Walker ☐ Wheelchair ☐ Stretcher ☐ Other:
Language(s) spoken/understood: ☐ Yes ☐ No ☐ Other ☐ Translator required	
Source of Information: ☐ Self ☐ Family ☐ Other:	**Age**
Reason for Admission:	

Primary Lifetime Occupation:	**Education:**	**Name you wish to be called:**
Allergies: ☐ None Known ☐ Medi Alert on ☐ Agency Alert on ☐ Facility specific Allergy/Intolerance record completed (if applicable) *(describe reaction(s))* ☐ Drug: ☐ Food:		☐ Latex: ☐ Environment:
Key Contact: *(name, relationship, tel # s)*		
Legal Substitute Health Care Decision Maker ☐ Proxy ☐ Personal Guardian ☐ Nearest relative ***(name, relationship, tel # s)***		Copy of docs: ☐ Proxy ☐ Personal Guardian
Advance Care Plan (Health Care Directives): ☐ Yes ☐ No ☐ On file Location of form:		
Other contact: *(name, relationship, phone #'s)* 1.		
Financial Power of Attorney:		

	QUESTIONS	YES	NO	PATIENT'S RESPONSE AND INTERVIEWER'S COMMENTS
PERSONAL HYGIENE	**Personal care assistance** (describe specific routines) **bathing** upper body			☐ Tub ☐ Shower ☐ Other:
	bathing lower body			
	grooming			
	oral care			
	dressing upper body			
	dressing lower body			
	assistance provided			☐ Family ☐ Home Care ☐ LTC ☐ Day Care
	devices used by patient			Hearing aid(es) ☐ Rt ☐ Lt ☐ With Patient Denture(s) ☐ Upper ☐ Lower ☐ Partial ☐ Caps ☐ At Home ☐ Glasses ☐ Contact lens ☐ Other:
ELIMINATION	**Difficulty with bowel care** *(describe problem and help needed)*			☐ Constipation ☐ Diarrhea ☐ Incontinence ☐ Laxative use *(what and how often)* ☐ Other: Bowel Pattern: ☐ daily ☐ EOD ☐ q 3 days ☐ Other: Date of last BM: Aids used: ☐ Pads ☐ Liners ☐ Briefs/Pull-ups ☐ Other:
	Difficulty with bladder care *(describe problem and help needed)*			☐ Incontinence ☐ Frequency *(how often)* ☐ Nocturia *(# of times up)* Toileting regime: ☐ Indwelling Catheter: *(size/ type)* Freq. of change: q ☐ Intermittent catheter q Date of last change: Aids used: ☐ Pads ☐ Liners ☐ Briefs/Pull-ups ☐ Other:
NUTRITION	**Specific diet** *(specify)*			☐ Regular ☐ Other: Nutritional Pattern: ☐ 3 regular meals ☐ 6 small meals ☐ hs snack ☐ between meal snacks ☐ Other:
	Food intolerance (specify)			
	Difficulty eating/drinking			☐ Difficulty chewing ☐ Dysphagia ☐ Recent weight gain ☐ Recent weight loss ☐ NPO ☐ Last ate: ☐ Last drank:
MOB	**Physical disabilities** *(describe help needed)*			☐ See TLR Assessment Mobility Record

MOB

Devices used by patient	Yes	No			
			☐ Walker ☐ Cane ☐ Wheelchair	☐ Prosthesis: *(list)* ☐ Orthopedic: *(list)* Other:	☐ With Patient ☐ At Home

OBSERVATIONS AND MEASUREMENTS

T ºC	P	R	BP	SpO_2 %	Blood Glucose mmol/L	Apical Pulse	Pedal Pulse (R) (L)	Weight kg	Height 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 ☐ Dizziness ☐ Vertigo ☐ Unsteadiness ☐ Disoriented ☐ Memory loss ☐ Headache ☐:Other: ☐ Pupils unequal ☐ Speech slurred ☐ Paraplegia ☐ Quadriplegia ☐ Hemiplegia ☐ Hemiparesis ☐ Motor/Sensory loss	☐ Seizure disorder ☐ Stroke ☐ TIA ☐ Cerebral palsy ☐ Multiple Sclerosis ☐ Alzheimer's ☐ Other dementia ☐ Other: ☐ Traumatic brain injury ☐ Parkinson's disease ☐ Migraine headaches ☐ Headaches ☐ Depression ☐ Panic attacks ☐ Diabetic Neuropathy	
CVS ☐	☐ Heart murmur ☐ Cyanosis ☐ Edema ☐ Other: ☐ Arrhythmias ☐ Tachycardia ☐ Bradycardia	☐ CHF ☐ Hypertension ☐ Hypotension ☐ Anemia ☐ Blood disorder ☐ Rheumatic fever ☐ Syncope ☐ Chest pain ☐ MI ☐ Angina ☐ Cardiac dysrhythmia ☐ ASHD ☐ VTE ☐ PVD ☐ Varicose Veins ☐ Other:	☐ Pacemaker ☐ Implanted cardioverter/ defibrillator
Resp ☐	☐ Shallow ☐ Rapid ☐ Slow ☐ Dyspnea ☐ Other: ☐ Wheezing ☐ Cough ☐ SOB	☐ Asthma ☐ Pneumonia ☐ Bronchitis ☐ Sleep Apnea ☐ Other: ☐ Frequent URI ☐ COPD ☐ Emphysema ☐ TB	☐ Chest sounds clear ☐ Uses CPAP/BiPAP ☐ Other:
GI ☐	☐ Flatulence ☐ Distension ☐ Lump ☐ Obesity ☐ Asymmetry ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Emesis ☐ Indigestion ☐ Heartburn ☐ Other:	☐ Bulimia ☐ Hiatus hernia ☐ Umbilical hernia ☐ Stomach pain ☐ Other pain ☐ Other: ☐ Cholelithiasis ☐ Anorexia ☐ Ulcer ☐ Hemorrhoids	☐ See Elimination ☐ Bowel sounds normal x 4 quadrants ☐ Other:
GUR ☐	☐ Discharge ☐ Blood in urine ☐ Lesions ☐ Burning ☐ Other:	☐ Cystocele ☐ Rectocele ☐ Kidney problems ☐ Renal failure ☐ Sexually Transmitted Infection ☐ Other: ☐ Hysterectomy ☐ Menstrual problems ☐ Frequent UTI ☐ Prostate problems	☐ 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 ☐ Other:	☐ Psoriasis ☐ Herpes zoster ☐ Herpes simplex ☐ Eczema ☐ Other: ☐ Bruises easily ☐ Tattoos ☐ Piercings	☐ Facility-specific pressure sore risk tool completed
MS ☐	☐ Swelling ☐ Deformities ☐ Weakness/Atrophy ☐ Other: ☐ Limited ROM ☐ Spasms ☐ Amputation(s)	☐ Osteoporosis ☐ Osteoarthritis ☐ Gout ☐ Pathological fracture: ☐ Hip fracture (*last 6 months*): ☐ Rt ☐ Lt ☐ Other fracture (*last 6 months*): ☐ Pain: ☐ hip ☐ joint ☐ soft tissue ☐ bone ☐ Rheumatoid arthritis ☐ Scoliosis ☐ Back problems/pain ☐ Other:	☐ See Mobility Record ☐ See PT/OT assessment
EENT ☐	☐ Deafness ☐ Hoarseness ☐ Blurred vision ☐ Nystagmus ☐ Other: ☐ Facial paralysis ☐ Aphasia ☐ Discharge ☐ Conjunctivitis ☐ Tracheotomy	☐ Diabetic retinopathy ☐ Macular degeneration ☐ Glaucoma ☐ Cataracts ☐ Other: ☐ Hearing problems ☐ Sinusitis ☐ Tinnitus	
ENDO ☐	☐ Exopthalmia ☐ Enlarged tongue ☐ Goiter ☐ Glucosuria ☐ Polydipsia ☐ Polyphagia ☐ Polyuria ☐ Other:	☐ Hyperthyroidism ☐ Hypothyroidism ☐ Other: ☐ Diabetes Mellitus Type 1 ☐ Diabetes Mellitus Type 2	

ADMISSION ASSESSMENT AND HISTORY REHABILITATION

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)*

FIM completed ☐ No ☐ Yes If yes, score:

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

	Yes	No	
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)* ☐ Other: ☐ Complementary therapies: *(list)*

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 ☐ Time off from work ☐ No telephone ☐ No running H_2O ☐ No drinkable H_2O supply ☐ No indoor plumbing
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 that affect care			
Clergy visit			Affiliation:
Substance use: **Alcohol**			☐ Within last 24 hours? *(how much)*
Tobacco			☐ Smoked within last 6 months ☐ Smoking policy explained Would you like assistance to quit smoking: ☐ No ☐ Yes
Illicit Drugs			
Other			
Difficulty sleeping at night *(why and what helps?)*			☐ Trouble getting to sleep ☐ Frequent waking *(how often)* ☐ Recent changes in sleep pattern ☐ 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	
Daily routine			☐ Other:	
If No, why not:				**ID(s):**