ADMISSION ASSESSMENT AND HISTORY – LONG TERM CARE – RESPITE/DAY PROGRAM

Date/Time of Admission:	**Source of information**: ☐ Self ☐ Family ☐ Other:	
Mode of Arrival to Unit: ☐ Walking ☐ Walker ☐ Wheelchair ☐ Stretcher ☐ Other:	**Language(s) spoken/understood:** ☐ En ☐ Fr ☐ Other: ☐ Translator required	**Age**
Reason for Admission:		

Allergies: *(describe reaction(s))* ☐ None Known ☐ Medi Alert on ☐ Facility-specific allergy/intolerance record completed ☐ Agency Alert on

☐ Drug:

☐ Food:

☐ Latex :

☐ Environment:

Key Contact: Name Relationship

Phone #s: H: W: C:

Legal Substitute Health Care Decision Maker:
Name
☐Proxy ☐Personal Guardian ☐Nearest Relative
Copy of docs: ☐ Proxy ☐ Personal Guardian
Ph #s H: W: C:

Advanced Care Plan (Health Care Directives): ☐ No ☐ Yes ☐ On file Location: _____

		Yes	No	
PH	**Personal care assistance**			☐ Bathing ☐ Grooming ☐ Oral Care ☐ Dressing
	Devices brought			Dentures: ☐ U ☐ L ☐ Loose teeth ☐ Glasses ☐ Contact lens Hearing aid(s): ☐ Rt ☐ Lt
ELIM	**Bowel care difficulties**			Bowel pattern: ☐ daily ☐ EOD ☐ Other: Date of last BM:
	Bladder care difficulties			☐ Nocturia *(# of times up)* Indwelling catheter: *(size and type)* Aids used: ☐ Pads ☐ Liners ☐ Briefs /Pull ups ☐ Other: Date last changed:
NUTR	**Meal time assistance**			Diet: ☐ Reg ☐ Other: Nutritional Pattern: Help required with eating:
MOB	**Ambulation assistance**			**TLR Agencies use Mobility Record** ☐ See Mobility Record
	Devices brought			☐ Cane ☐ Walker ☐ Wheelchair ☐ Prosthesis (list)

OBSERVATIONS AND MEASUREMENTS

Pain ☐Unable to verbalize pain ☐ non-verbal evidence demonstrated by the following symptoms:
Standardized pain observation tool: _____
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):

Temp °C	**Pulse** ☐ Radial ☐ Apical	**Resp/min**	**BP**	**HT** cm	**WT** kg	**SpO₂** %	**Pedal Pulses** Rt Lt	**Blood Glucose** **mmol**/L

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 ☐ Other:	☐ Seizure disorder ☐ Alzheimer's ☐ Stroke ☐ Other dementia ☐ TIA ☐ Multiple Sclerosis ☐ Cerebral palsy ☐ Migraine headaches ☐ Parkinson's disease ☐ Headaches ☐ Traumatic brain injury ☐ Depression ☐ Other: ☐ Panic attacks ☐ Diabetic Neuropathy	
CVS ☐	☐ Heart murmur ☐ Arrhythmias ☐ Cyanosis ☐ Tachycardia ☐ Edema ☐ Bradycardia ☐ Other:	☐ CHF ☐ Rheumatic fever ☐ Hypertension ☐ MI ☐ Hypotension ☐ Angina ☐ Anemia ☐ ASHD ☐ Blood disorder ☐ VTE ☐ Chest pain ☐ PVD ☐ Syncope ☐ Cardiac dysrhythmia ☐ Other:	☐ Pacemaker ☐ Implanted cardioverter/ defibrillator
Resp ☐	☐ Shallow ☐ Wheezing ☐ Rapid ☐ Cough ☐ Slow ☐ SOB ☐ Dyspnea ☐ Other:	☐ Asthma ☐ Frequent URI ☐ Pneumonia ☐ COPD ☐ Bronchitis ☐ Emphysema ☐ Other: ☐ TB	☐ Chest sounds clear ☐ Uses CPAP/BiPAP ☐ Other:
GI ☐	☐ Flatulence ☐ Diarrhea ☐ Distension ☐ Nausea ☐ Lump ☐ Emesis ☐ Obesity ☐ Indigestion ☐ Asymmetry ☐ Heartburn ☐ Constipation ☐ Other:	☐ Bulimia ☐ Cholelithiasis ☐ Hiatus hernia ☐ Anorexia ☐ Umbilical hernia ☐ Ulcer ☐ Stomach pain ☐ Hemorrhoids ☐ Other:	☐ See Elimination for additional information ☐ Bowel sounds normal x 4 quadrants ☐ Other:

OBSERVATIONS AND MEASUREMENTS

NORMAL FINDINGS	ABNORMAL SIGNS	HISTORY/CURRENT MEDICAL CONDITIONS	COMMENTS
GUR ☐	☐ Discharge ☐ Blood in urine ☐ Lesions ☐ Burning ☐ Other:	☐ Cystocele ☐ Kidney problems ☐ Rectocele ☐ Renal failure ☐ Hysterectomy ☐ Frequent UTI ☐ Menstrual problems ☐ Prostate problems ☐ Sexually transmitted infection ☐ Other:	☐ See Elimination for additional information LMP *(date)* ☐ NA
Integ ☐	☐ Bruising ☐ Rash ☐ Dry ☐ Lesions ☐ Pale ☐ Diaphoretic ☐ Abrasions ☐ Flushed ☐ Dehydrated ☐ Ulcer ☐ Jaundice ☐ Oily ☐ Pruritus ☐ Cyanosis ☐ Lumps ☐ Other:	☐ Psoriasis ☐ Eczema ☐ Herpes zoster ☐ Bruises easily ☐ Herpes simplex ☐ Other:	☐ See Wound Record
MS ☐	☐ Swelling ☐ Limited ROM ☐ Deformities ☐ Spasms ☐ Weakness/Atrophy ☐ Amputation(s) ☐ Other:	☐ Rheumatoid arthritis ☐ Osteoporosis ☐ Osteoarthritis ☐ Scoliosis ☐ Gout ☐ Back problems/pain ☐ Pathological fracture: ☐ Hip fracture *(last 6 months)*: ☐ Rt ☐ Lt ☐ Other fracture *(last 6 months)*: ☐ Pain: ☐ hip ☐ joint ☐ soft tissue ☐ bone ☐ Other:	☐ See Mobility Record for additional information
EENT ☐	☐ Deafness ☐ Facial paralysis ☐ Hoarseness ☐ Aphasia ☐ Blurred vision ☐ Dysphasia ☐ Nystagmus ☐ Discharge ☐ Tracheotomy ☐ Conjunctivitis ☐ Other:	☐ Diabetic retinopathy ☐ Hearing problems ☐ Macular degeneration ☐ Sinusitis ☐ Glaucoma ☐ Tinnitus ☐ Cataracts ☐ Other:	
ENDO ☐	☐ Exopthalmia ☐ Polydipsia ☐ Enlarged tongue ☐ Polyphagia ☐ Goiter ☐ Polyuria ☐ Glucosuria ☐ Other	☐ Diabetes Mellitus Type 1 ☐ Hyperthyroidism ☐ Diabetes Mellitus Type 2 ☐ Hypothyroidism ☐ Other:	

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

Date of pneumococcal vaccine:

Date of last influenza immunization:

Date of last TB test:

☐ **Facility ARO screening tool completed**

Treated for Antibiotic Resistant Organisms (ARO(s)) ☐ No ☐ Not known ☐ Yes *(describe)* ☐ VRE ☐ MRSA ☐ Other:

Date of last hospitalization *(when, where and why)*

History pertinent to this admission:

MEDS

Presently taking Medications: ☐ **Yes** ☐ **No** ☐ See Best Practice Medication History (BPMH)

Pharmacy of Choice: *(Name and Location)*

TX AND PRO

	Yes	**No**	
Previous blood transfusion(s) *(describe reactions, if any)*			
Present treatments *(describe)*			☐ O_2 ☐ Ostomy care ☐ Trach. Care ☐ OT ☐ Physio ☐ Chiropractic ☐ Home Care ☐ Adult Day Program ☐ Complementary Therapies: *(describe)* ☐ Other:

TE

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

☐ Risk for wandering

PS

Substance use *(when, how much)*			☐ Alcohol ☐ Tobacco ☐ Illicit drugs

Mental, emotional, behavioral status

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

☐ Facility-specific depression screening completed

INDIVIDUAL CARE PLAN – LONG TERM CARE – RESPITE/DAY PROGRAM

	INITIATOR	DESIRED OUTCOME	OUTCOME MET / ID	INITIATED DATE / ID	INTERVENTIONS	DISC DATE / ID
PERSONAL HYGIENE	☐ Bathing ☐ Grooming ☐ Oral	Maintain cleanliness and comfort			Dependent	
	☐ Dressing ☐ Hygiene				Assist with	
	self care deficit r/t					
					Self care	
ELIMINATION	R/f constipation r/t	BM q _____ days				
					Self care	
NUTRITION					☐ Reg ☐↓ Na ☐ Other:	
					Self feed	
MOBILITY	Impaired physical mobility r/t	Maintain mobility level			☐ 2 person lift ☐ 1 person lift	
					☐ mechanical lift:	
					Assistive devices:	
					Self mobile	

	INITIATOR	DESIRED OUTCOME	OUTCOME MET / ID	INITIATED DATE / ID	INTERVENTIONS	DISC DATE / ID
OBS AND MEAS	RO				VS BP	
MEDS	DO				See Med Record	
					See IV Record	
TX AND PRO	R/f impaired skin integrity r/t	Early detection of complications				
TEACHING	Deficit knowledge:	Verbalizes understanding of			Explain diagnostic tests, procedures	
	r/t					
SAFETY	R/f injury r/t	No injuries				
PSYCHOSOCIAL	Anxiety r/t	Verbalization of ↓ feelings of			Keep pt/significant other informed and	
		anxiety			encourage verbalization of feelings	