**ADMISSION HISTORY AND TEACHING RECORD HOME CARE**

**Date/Time of Admission**

Source of Referral: □ Hospital □ Physician □ Other:

Reason for Referral: □ IV Therapy □ Other:

**Medical Diagnosis:**

**Family Physician:**

Other Physicians:

**Procedure and Date:**

Allergies: list and describe reactions (s) □ None Known □ Medi Alert on □ Facility/unit-specific Allergy/Intolerance record completed (if applicable) □ Facility/unit-specific ARO screening tool completed (if completed, then the following questions can be omitted) □ Known Allergy/Intolerance record completed

Drugs:

Food:

Language Spoken: □ En □ Fr □ Other:

Translator Required: □

Latex:

Environment:

Key Contact: (name, relationship, ph #)

**Legal Substitute Health Care Decision Maker:** □ Proxy □ Personal Guardian □ Nearest relative □ Other:

Copy of docs: □ Proxy □ Personal Guardian

**Advance Care Plan (Health Care Directives):** □ Yes □ No □ On File

**Financial Power of Attorney**

(name, ph #)

**QUESTIONS**

**P.H.**

Difficulty with personal care (describe)

**E.L.I.M.**

Difficulty with bowels/bladder (describe)

**N.U.T.R.**

Assistance required

**M.O.B.**

Physical limitations (walking/stairs, tolerance)

Devices used □ Cane □ Walker □ Wheelchair □ Prosthesis: □ Other:

TLR Agencies □ See Mobility Record

**System Assessment/Medical History**

(designate □ NA □ See Assessment Addendum □ Hi

**O.B.S.E.R.V.A.T.I.O.N.S AND MEASUREMENTS**

System Assessment/Medical History (describe) □ NA □ See Assessment Addendum □ Hi

**Pain**

□ Unable to verbalize pain □ non-verbal evidence demonstrated by the following symptoms: 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):

**CNS -** Neurological Disorder □ Other:

**CVS -** □ Heart Disease □ Arrhythmia □ Murmur □ Valve Replacement/Stent □ Hypertension □ Stroke □ Bleeding Disorder □ Other:

**RESP -** □ Respiratory Disease □ Other:

**GI -** □ G1 Disorder □ Other:

**GU -** □ Kidney Disease □ Other:

**INTEG -** □ Bruising □ Other:

**MS -** □ Musculoskeletal Disorder □ Other:

**ENT -** □ Vision /Hearing Disorder □ Other:

**ENDO -** □ Diabetes □ Other:

**Pertinent History**

History of: □ HIV □ Hepatitis □ TB □ Other:

□ Facility/unit ARO screening tool completed (if completed, then the following questions can be omitted)

**Infection Control:** Precautions Required □ No □ Yes (describe)

**History of ARO:** □ Unknown □ No □ Yes (describe) □ VRE □ MRSA □ TB □ Other:

Currently being treated for the above: □ No □ Yes (describe)

**Date of last TB test, results and history:**

**Date of last influenza immunization:**

**Date of pneumococcal vaccine:**

**Facility/unit specific pressure ulcer risk assessment completed**

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

**Pharmacy of Choice:** (location, ph #)

**T.Y.S. AND P.R.O.**

Present treatment(s): □ IV Therapy □ Other:

Laboratory test(s) done: □ None □ Cultures □ Urine □ Blood □ Sputum □ Wound □ Other:

Date(s) done:

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### Teaching Record

**Teaching required:**
- [ ] IV Care
- [ ] Medication Administration
- [ ] Blood Monitoring
- [ ] Rx from Physician

#### Safety

- [ ] 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

#### Preventative Measures being used/needed:
- [ ] NA

#### Psychosocial

**Family/friends/agencies for:**
- Support
- Transportation
- Check on Patient
- Pick up supplies

**Home management concerns:**
- [ ] Adult Day Program
- [ ] Lives alone
- [ ] No telephone
- [ ] No running water
- [ ] Laundry
- [ ] Homemaking
- [ ] Outside maintenance

**Substance Use:**
- alcohol
- [ ] tobacco
- OTC/Rx/illicit drugs
- Other:

**Assessment of mental/emotional status:**
- [ ] (mood, thought, behaviour)

- [ ] See Assessment Addendum
- [ ] Facility-specific depression screening completed

#### Date/Time and ID

**Handouts Given:**
- [ ] Drug Monogram
- [ ] IV Therapy Booklet
- [ ] Medication Administration Instruction
- [ ] Treatment Centre Pamphlet
- [ ] Other (describe):

#### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Teaching – Date: Instructions Given</th>
<th>Key/ID</th>
<th>Reinforcement – Date: Instructions Reinforced</th>
<th>Key/ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Therapy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medication Admin</td>
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<td>Other:</td>
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<td>Other:</td>
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**Follow-up**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Instructions Given</th>
<th>Key/ID</th>
<th>Instructions Reinforced</th>
<th>Key/ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Urine Testing</td>
<td></td>
<td></td>
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<tr>
<td>Physician Visit</td>
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<tr>
<td>Infectious Disease Clinic</td>
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**Additional Comments:**