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)*
☐ Drugs:
☐ Food:
☐ Latex:
☐ Environment:

Language Spoken: ☐ En ☐ Fr ☐ Other:
☐ Translator Required

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

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:**

Financial Power of Attorney *(name, ph #)*

	QUESTIONS	YES	NO	PATIENT'S RESPONSE AND INTERVIEWERS COMMENTS
PH	**Difficulty with personal care** *(describe)*			
ELIM	**Difficulty with bowels/bladder** *(describe)*			
NUTR	**Assistance required**			
MOB	**Physical limitations** *(walking/stairs, tolerance)*			
	Devices used			☐ Cane ☐ Walker ☐ Wheelchair ☐ Prosthesis: ☐ Other: **TLR Agencies** ☐ See Mobility Record

OBSERVATIONS AND MEASUREMENTS

System Assessment/Medical History *(describe)* ☐ NA ☐ See Assessment Addendum **Ht** **Wt**

T	P	R	BP	BS	SpO2

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 – ☐ GI Disorder ☐ Other:

GU - ☐ Kidney Disease ☐ Other:

INTEG - ☐ Bruising ☐ Other:

MS - ☐ Musculosketal Disorder ☐ Other:

EENT - ☐ Vision /Hearing Disorder ☐ Other:

ENDO – ☐ Diabetes ☐ Other:

Pertinent History **Infection Control:** Precautions Required ☐ No ☐ Yes *(describe)*
History of: ☐ HIV ☐ Hepatitis ☐ TB ☐ Other:
☐ **Facility/unit ARO screening tool completed** *(if completed, then the following questions can be omitted)*
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

MED

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

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

TXS AND PRO

Present treatment(s): ☐ IV Therapy ☐ Other:
Laboratory test(s) done: ☐ None ☐ Cultures ☐ Urine ☐ Blood ☐ Sputum ☐ Wound ☐ Other:
Date(s) done:

TE	**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:	**Yes**	**No**	**Comments**:
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			**Comments**:
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

TEACHING RECORD

Key:
U – Understood
R – Reinforcement needed, comment needed
N – No understanding, comment needed
✓ - See additional comments
NA – Not applicable

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

ACTIVITY	TEACHING – DATE:		REINFORCEMENT – DATE:	
	INSTRUCTIONS GIVEN	KEY/ID	INSTRUCTIONS REINFORCED	KEY/ID
IV Therapy				
Medication Admin				
Other:				
Other:				
FOLLOW-UP	**INSTRUCTIONS GIVEN**	**KEY/ID**	**INSTRUCTIONS REINFORCED**	**KEY/ID**
Blood Work				
Urine Testing				
Physician Visit				
Infectious Disease Clinic				
Other:				
Other:				

Additional Comments