GENERAL ADMISSION ASSESSMENT AND HISTORY

☐ **Verification of patient ID band**
Admission – Date/Time ☐ See Notes

Diagnosis:

Reason for admission:

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

Legal Substitute Health Care Decision Maker: *(name, relationship, ph#)*

☐Proxy ☐ Personal Guardian ☐Nearest relative

Financial Power of Attorney:
Name: Phone#:

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

Occupation / Education:

Source of Information ☐ Self ☐ Other:

Age

Additional Contacts: (*name, relationship, ph#)*

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

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

	QUESTIONS	YES	NO	PATIENT'S RESPONSE AND INTERVIEWER'S COMMENTS
PERSONAL HYGIENE	**Do you need assistance with personal care at home regarding bathing, grooming, oral care and dressing?** *(describe specific routines)*			☐ Tub ☐ Shower ☐ Other:
	assistance provided			☐ Family ☐ Home Care ☐ LTC ☐ Day Care
	devices used by patient at home			Hearing aid(s) ☐ Rt ☐ Lt Denture(s) ☐ Upper ☐ Lower ☐ Partial ☐ With Patient ☐ Glasses ☐ Contact lens ☐ Other: ☐ At Home
ELIMINATION	**Difficulty with bowel care** *(describe problem and help needed)*			☐ Constipation ☐ Diarrhea ☐ Incontinence ☐ Colostomy Change due: ☐ 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 ☐ Indwelling Catheter*(size/ type)* Aids used: ☐ Frequency *(how often)* ☐ Pads/ Liners ☐ Nocturia *(# of times up)* Freq. of change: q ☐ Briefs/Pull-ups ☐ Urostomy Change due: ☐ Intermittent catheter q ☐ Other: Toileting regime: Date of last change:
NUTRITION	**Specific diet** *(specify)*			☐ Regular ☐ NPO ☐ Other: ☐ Last ate: ☐ Last drank: 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:_____
MOBILITY	**Physical disabilities** *(describe help needed)*			☐ See TLR Assessment/ Mobility Record
	Devices used at home			☐ 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) (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	CURRENT ABNORMAL SIGNS	MEDICAL HISTORY	ASSESSMENTS
CNS ☐	☐ Tremors ☐ Pupils unequal ☐ Dizziness ☐ Speech slurred ☐ Vertigo ☐ Paralysis *(comment)* ☐ Unsteadiness ☐ Paresis *(comment)* ☐ Disoriented ☐ Motor/Sensory loss ☐ Headache ☐ Memory loss	☐ Seizure disorder ☐ Traumatic brain injury ☐ Stroke ☐ Parkinson's disease ☐ TIA ☐ Migraine headaches ☐ Cerebral palsy ☐ Headaches ☐ Multiple Sclerosis ☐ Depression ☐ Alzheimer's ☐ Panic Attacks ☐Diabetic Neuropathy	☐Other:
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:
GI ☐	☐ Flatulence ☐ Diarrhea ☐ Distension ☐ Nausea ☐ Lump ☐ Emesis ☐ Obesity ☐ Indigestion ☐ Asymmetry ☐ Heartburn ☐ Constipation	☐ Bulimia ☐ Cholelithiasis ☐ Hiatus hernia ☐ Anorexia ☐ Umbilical hernia ☐ Ulcer ☐ Stomach pain ☐ Celiac ☐ Hemorrhoids ☐Gastroparesis	☐ 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___ ☐ Other:
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	☐ Other: ☐ See Wound Record
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:

Additional comments:

GENERAL ADMISSION ASSESSMENT AND HISTORY

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:**

☐ **Facility/Unit specific Pressure Sore risk assessment completed**

☐ **Facility/Unit specific VTE risk assessment completed**

MEDICATIONS

Current Medications/Herbals: Presently taking meds ☐ Yes ☐ No ☐ See Best Possible Medication History (BPMH)

Pharmacy of Choice *(Name and Location):*

IV/ Sub cut/ CVAD/ Parenteral therapy (at time of admission) ☐ No IV at time of admission
☐ IV in situ ☐ Dressing intact ☐ No signs of infection ☐ Inflammation ☐ Redness ☐ Pain ☐ Exudate
☐ Sub cut ☐ PICC ☐ IVAD/ Port ☐ Other:

Location: Last line care done: Next due:

☐ Dialysis access site: Last dialysis treatment received: Next due:

Previous anesthesia/intubation ☐ Yes ☐No ☐If Yes, have you had any adverse reactions: ☐ Yes ☐No
(when and describe)

Previous blood transfusions ☐ Yes ☐No ☐If Yes, have you had any adverse reactions: ☐ Yes ☐No
(describe when, why)

TX AND PRO

Presently receiving any treatment(s) at home
(describe, including discipline(s) providing care)

☐ O_2 ☐ Trach. care ☐ Ventilator
☐ Ostomy care
☐ Skin/Wound care
☐ Foot care
☐ Pain therapy: *(list)*
☐ Complementary therapies: *(list)*

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

TE

Assessment of patient/family information and teaching needs

SAFETY

☐ **Facility/Unit specific Fall risk assessment completed** (if completed then this section can be omitted)

Morse Fall Scale	Variables	Score	Initial Assessment
History of falling	No	0	
	Yes	25	
Secondary diagnosis	No	0	
	Yes	15	
Ambulatory aid	None/ bed rest/ nurse assist	0	
	Crutches/ cane/ walker	15	
	Furniture	30	
IV or IV access	No	0	
	Yes	20	
Gait	Normal/ bed rest/ wheelchair	0	
	Weak	10	
	Impaired	20	
Mental Status	Knows own limits	0	
	Overestimates or forgets limits	15	
	ID: Total Score		

Reassessment is recommended after a fall, with a change in status and at discharge or transfer to a new setting.

☐ History of wandering
☐ Call Light/Bell within reach
☐ Brakes on bed
☐ Bed in most appropriate position

Safety precautions required *(describe)*

According to facility specific policy and if applicable:
☐Leaf sign on chart
☐Leaf sign outside room or above bed
☐Entered into electronic record

45 or higher = High Risk **25-44 = Moderate Risk** **0-24 = Low Risk**

Psychosocial

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

	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			☐ Will visit ☐ Will bring in supplies ☐ Counselors: *(list)*
Now			
On Discharge			☐ Access to transportation ☐ Someone to check on patient ☐ Home care needed ☐ Counseling follow up
Spiritual or Ethnical aspects affecting care			Religious affiliation: ☐ Desires clergy visit
Substance use: Alcohol *(describe when, why)*			☐ Within last 24 hours? *(how much)*
Tobacco screening program			Are you a smoker or tobacco user? ☐Yes ☐No *If Yes, please continue assessment* Are you willing to discuss your tobacco use? ☐Yes ☐No What do you think about quitting tobacco? Does the patient require additional support? ☐Yes ☐No ☐ Information/ pamphlet given to patient ☐ Smoking policy explained
Illicit Drugs or Other			
Difficulty sleeping at night *(why and what helps?)*			☐ Trouble getting to sleep Sleep Pattern: ☐ Frequent waking *(how often)* Time to bed: ☐ Recent changes in sleep pattern Time waking: ☐ Pain Daytime naps: ☐ AM ☐ PM ☐ Other:

PHQ-9 Depression Screen: Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
Little interest in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
If you checked "more than half the days" or "nearly every day" for at least ONE of the above questions, please complete the following questions.				
Trouble falling asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
Add columns				
ID: Total score				

Score: 0-4 is Minimal, 5-9 is Mild, 10-14 is Moderate, 15-19 is Moderately severe, 20-27 is Severe

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Additional Comments:

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