niagarahealth
Extraordinary Caring. Every Person. Every Time.

A7770020 AA17772222/YY
Test, Patient A 16/05/1976
Svc/AdmDate: 09/01/2006 M 32
Att: Welby, Marcus 555−44−2223
Fam: Isreal, Robert W.

Admission Data Base (Medical/Surgical/Critical Care)

Date/time of Admission _____ dd/mm/yyyy hh/mm Source of Information: Patient _____ Other: _____

Patient Id Band in place _____ 2 Patient Identifiers Confirmed _____

Presenting Problem/Chief complaint: _____

What are your expectations regarding your hospitalization/surgery? _____

Pertinent History of Past Illness/Operations Complications (include dates where applicable) None _____

Allergies: Verify, confirm and update allergy information and intolerances in Meditech. Updated: Initial_____
Red allergy band applied: ❑ Yes ❑ N/A

Vital Signs at Admission:

BP (Rt) _____ (Lt) _____ Temperature _____ Pulse _____ Respirations _____ O_2sat _____ ❑ R/A ❑ O_2@ _____ via _____

Height _____ Weight _____ (lb / Kg) ❑ Taken ❑ Stated ❑ Updated in OE

Canadian Nutrition Screening Tool (CNST)

1. Have you lost weight in the past 6 months WITHOUT TRYING to lose this weight? ❑ Yes ❑ No
2. Have you been eating less than usual FOR MORE THAN A WEEK? ❑ Yes ❑ No

Two **YES** answers indicate a nutrition risk. Please initiate a referral to the Registered Dietitian for further assessment

Dietitian Referral entered into Order Entry (MALNURISK) ❑ Yes _____ (Staff initials)

Home Medications:

Verify that the Best Possible Medication History (Form ORD37) was completed prior to admission ❑ Yes ❑ No (complete if not done)

Medications brought to the hosptial: ❑ Yes ❑ No ❑ Sent home ❑ Secure in Patient care unit in designated area and send home as soon as possible

Substance Use assessment:

Chemical/Substance Usage:
Smoking / Use nicotine products: ❑ Yes ❑ No Amount/day _____ Quit when: _____

Alcohol Use:
Do you drink alcohol? ❑ Yes ❑ No
If **Yes**; how many drinks do you have on a typical day when you drink? ❑ 1−2 ❑ 3−4 ❑ 5−6 ❑ 7−9 ❑ 10+
When was your last drink? ❑ <24 hours ❑ 1−3 days ago ❑ In the past week ❑ In the past month ❑ >1 month ago

What other substances have you used in the past year?
❑ Amphetamines/stimulants ❑ Cocaine/crack cocaine ❑ Cannabis ❑ Ecstasy ❑ GHB ❑ Hallucinogens (LSD, PCP)
❑ Ketamine ❑ Opioids−(Heroin, Oxycodone) ❑ Steroids ❑ Other:
If Yes, when was last use: ❑ <24 hours ❑ 1−3 days ago ❑ In the past week ❑ In the past month ❑ >1 month ago
Non−medical injection drug use: ❑ Never ❑ >1 year ago ❑ In the last year ❑ Unknown

If positive to use of substances (alcohol and/or drugs) then ask CAGE−AID Screening Questions:

1. Have you ever felt you ought to **C**ut down on your drinking (or drug use? ❑ Yes ❑ No
2. Have people ***A**nnoyed* you by criticizing your drinking (*or drug use)*? ❑ Yes ❑ No
3. Have you ever felt bad or ***G**uilty* about your drinking (*or drug use)*? ❑ Yes ❑ No
4. Have you ever had a drink (or used drugs) first thing in the morning (**E**ye−opener) to steady your nerves or to get rid of a hangover? ❑ Yes ❑ No

If CAGE−AID positive offer Addictions Counselling referral

Advance Directives:

Do you have an advance directive? ❑ Yes ❑ No Did you bring a copy with you to hospital? ❑ Yes ❑ No
Do you have a Power of Attorney for your personal health? ❑ Yes ❑ No
If "yes", Name _____ Phone Number _____ (work) _____ (home)
Do you have a Power of Attorney for your Finances? ❑ Yes ❑ No
If "yes", Name _____ Phone Number _____ (work) _____ (home)
(complete if different from Power of Attorney for personal health)

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Systems Assessment Standard:

Respiratory Assessment
❑ Resp 10−20 min/quiet regular: breath sounds clear; No cyanosis; no cough; sputum clear

Breath Sounds
❑ Abnormal rate
❑ Short of Breath
❑ Shallow
❑ Cough
❑ Sputum _____ (describe)
❑ Laboured
❑ Use of Accessory Muscles
❑ Crackles
❑ RUL / RML / RLL
❑ LUL / LLL
❑ Wheezes present
❑ Inspiration
❑ Expiration
❑ RUL / RML / RLL
❑ LUL / LLL
❑ COPD / Asthma
❑ Sleep Apnea
Oxygen:
❑ O_2 in use _____% L/min
Oxygen Delivery Mode:
❑ Mask ❑ Prongs ❑ Assisted Ventilation
Comments: _____

Cardiovascular Assessment
❑ Regular apical/radical pulse; peripheral pulses palpable; No edema; No calf tenderness: Capillary refill ≤ 3 sec

Apical Pulse _____ min. ❑ Irregular

Peripheral Pulses

	Rt	Lt		
Radial	❑	❑	❑ Diminished	❑ Absent
Pedal	❑	❑	❑ Diminished	❑ Absent

Edema _____
Calf Tenderness ❑ Rt ❑ Lt
Pacemaker ❑ Yes ❑ No
Comments _____

History:
❑ Heart Failure
❑ CVA
❑ Coronary Artery Disease
❑ Hypertension
❑ Heart attack

Gastrointestinal Assessment
❑ Abd. Soft: non−tender; Bowel sounds present in all 4 qudrants. Absence of Nausea/vomiting; normal BM's within own pattern
Record
i) Date of last BM (dd/mm/yyyy) _____

ii) Pt's usual pattern _____

❑ Nausea ❑ Diarrhea ❑ Rectal Bleeding
❑ Vomiting ❑ Constipation ❑ Involuntary of stool

Bowel sounds (circle location)
❑ Absent RUQ RLQ LUQ LLQ
❑ Diminished RUQ RLQ LUQ LLQ
❑ Hyper RUQ RLQ LUQ LLQ

Describe _____

Abdomen
❑ Firm
❑ Distended
❑ Tender
❑ Rebound
❑ Guarding

History:
❑ Inflammatory Bowel Disease
❑ Other _____

❑ Colostomy ❑ Ileostomy ❑ N/G Tube ❑ Peritoneal Catheter
❑ Use of bowel aids
Other comments _____

Genitourinary Assessment
❑ Normal voiding patterns; Urine clear/yellow

❑ Dysuria ❑ Retention ❑ Hematuria ❑ Anuria
❑ Urgency ❑ Distension ❑ Polyuria ❑ Oliguria
❑ Frequency ❑ Incontinence ❑ Nocturia ❑ Dialysis
Catheter Date inserted _____ dd/mm/yyyy
❑ Foley ❑ Suprapubic ❑ Ileal Conduit
Other comments _____

Fluid/Electrolyte Assessment
❑ Moist mucous membranes, good tissue turgor; Normal fluid intake; No IV therapy running

❑ Dry skin ❑ Poor turgor ❑ Central Venous Access Device (CVAD)
❑ Dry mucous membranes Type _____ Site _____
IV Site _____ Catheter size _____
Solution _____ Rate _____ Amt TBA _____
Date inserted (ddmmyyyy)_____
Other comments _____

Integumentary Assessment
❑ Skin/nails clean and intact; Skin colour within patient's norm; Normal temp. of skin to touch

Complete Braden Scale Assessment (NUR37)

❑ Cool
❑ Hot
❑ Diaphoretic
❑ Red/Inflamed
❑ Jaundiced
❑ Pallor
❑ Rash
❑ Hives
❑ Burn
❑ Bruising
❑ Nail Problems
❑ Lacerations
❑ Abrasions
❑ Discharge
❑ Pressure Ulcers (Complete Wound Assessment Flow Sheet FLOW009 if present)
Other comments _____

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Wound/Incision Dressing Assessment ❑ Incision clean, dry, intact with no tenderness; sutures/staples/Steri−Strips intact; (specify location if more than 1)	❑ Redness ❑ Gaping ❑ Warm to touch ❑ Drainage (amt/colour/odour) _____ ❑ Drainage Devices Type _____ Date inserted (ddmmyyyy)_____ Location _____ Drainage (amt/colour/odour) _____ Other comments _____
Musculoskeletal Assessment ❑ Normal ROM; No muscle weakness; absence of deformities in joints, bones, muscles. Absence of inflamed joints and joint tenderness (specify sites)	❑ Limited ROM _____ ❑ Inflamed Joints _____ ❑ Muscle/Joint tenderness _____ ❑ Deformity _____ ❑ Weakness _____ Other comments _____
Neurological Assessment ❑ Alert, orientated to person place and time, Verbilizations clear and understandable; Memory intact, Sensations intact	Disoriented to: ❑ Dementia Language: ❑ Person ❑Clouded Sensorium ❑ Slurred ❑ Place ❑ Stuporous ❑ Difficulty understanding ❑ Time CAM/bCAM ❑ Positive (Delirium) ❑ Negative ❑ Confused ❑ Dizzy ❑ Sedated ❑ Lethargic ❑ Glasgow Coma Scale initiated ❑ Blurred Vision ❑ Seizures ❑ Canadian Neurological Scale Initiated ❑ Numbness ❑ Comatose Other Comments _____
Pain Assessment ❑ Patient does not verbalize pain or exhibit any signs or symptoms of pain *Record pain score _____ If pain present complete: Comprehensive Pain assessment Tool (ASSMT025)	❑ Acute ❑ Chronic ❑ Palliative Location _____ Aggravating factors _____ Radiates to _____ Frequency _____ Alleviating Factors _____ Scale (0−10) _____
Mental Status Assessment ❑ A B C (Appearance, Behavioural, Cognition) appropriate for circumstances	**Appearance, affect, and anxiety**: Hygiene: ❑ Kempt ❑ Disheveled ❑ Soiled ❑ Body odour, Dress: ❑ Underdressed ❑ Overdressed ❑ Bizarre Affect(mood): ❑ Euphoric ❑ Elevated ❑ Euthymic(normal mood) ❑ Despondent ❑ Depressed Anxiety: ❑ Calm ❑ Tense ❑ Anxious ❑ Fearful ❑ Panicked ❑ Agitated ❑ Irritable ❑ Angry **Behavior:** Movements: ❑ Normal rate ❑ Hyperactive ❑ Hypoactive Organization: ❑ Organized ❑ Distractibility ❑ Incoherent/disorganized Purpose: ❑ Goal−oriented ❑ Cooperative ❑ Uncooperative ❑ Bizarre ❑ Stereotypical/repetitive ❑ Hostile/aggressive Speech: Rate: ❑ Normal ❑ Rapid ❑ Slow, Quality: ❑ Disorganized ❑ Incoherent ❑ Slurred ❑ Mumbled ❑ Mutism **Cognition:** Memory deficit: ❑ Remote ❑ Recent ❑ Immediate recall Reasoning: ❑ Impaired insight ❑ Impaired judgment ❑ Impaired problem solving ❑ Distractibility Coherence: ❑ Incoherent ideas ❑ Delusional beliefs, Hallucinations: ❑ Auditory ❑ Visual ❑ Tactile ❑ Olfactory ❑ Gustatory ❑Violence Risk (Complete: Behaviour Profile form 900837) ❑ Restraints Required (Complete: Restraint Initiation Record NUR31)
Mobility ❑ Steady gait; ambulates independently; no recent changes with mobility Complete Falls Risk Assessment Form and Intervention Tool (NUR5)	Recent change in mobility ❑ Yes ❑ No If yes, describe: _____ ❑ Unsteady gait ❑ Impaired balance Ambulatory Aids _____ ❑ Bariatric − Initiate Bariatric Assessment Tool and Care Plan (NUR21) Lift/Transfer: ❑ 1 person ❑ Sit to Stand lift ❑ 2 person ❑ Mechanical Lift Other comments: _____

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Activity/Rest ❑ No sleep disturbances; Verbalizes rest/sleep/physical activity is adequate	❑ Insomnia ❑ Fatigue ❑ Inactive Life Style ❑ Sleep Aides _____ Other comments: _____
ADL Functional Assessment ❑ Independently able to perform self−grooming activities without difficulty; Able to feed self, requires no assistance with tray set−up;	Independent / Needs Assistance / Dependent Eating ❑ ❑ ❑ Bathing ❑ ❑ ❑ Dressing ❑ ❑ ❑ Toileting ❑ ❑ ❑ Communication needs ❑ ❑ ❑
Nutrition ❑ tolerates regular diet; No diet intolerances; Normal appetite; (75−100%) No purposeful weight gain/loss in the past 3−6 months. No swallowing or chewing problems.	❑ Special Diet _____ ❑ Supplements _____ ❑ Difficulties with chewing ❑ Choking and/or coughing when eating solids or swallowing liquids ❑ Yes ❑ No If **yes,** please request an order for a Speech −Language Pathologist consult Other comments _____
Sensory ❑ No hearing/visual/oral deficits	❑ Hearing aid ❑ Rt ❑ Lt ❑ Glasses ❑ At all times ❑ Reading ❑ Legally Blind ❑ Rt ❑ Lt ❑ Contact lens ❑ Cataracts ❑ Rt ❑ Lt **Teeth:** ❑ Caps ❑ Loose teeth ❑ Bridge ❑ Permanent ❑ Partial ❑ Braces **Dentures:** ❑ Upper ❑ Partial ❑ Full ❑ Lower ❑ Partial ❑ Full **On Admission:** Glasses/contact lens with patient ❑ Yes ❑ No Hearing aid with patient ❑ Yes ❑ No Eye/ear aids labeled at time of admission ❑ Yes ❑ No Dentures present on admission ❑ Yes ❑ No Other Comments: _____

Admission Checklist:
Oriented to:
Call Bell System ❑ Yes ❑ No Unit Routines ❑ Yes ❑ No Room ❑ Yes ❑ No Visiting Hours ❑ Yes ❑ No

Discharge Planning Screening Tool:
❑ Completed at Pre−op Clinic ❑ Discharge Planning

Category I − Discharge Planning must be notified if any one of the following apply:

❑ Admitted with fall, seizure, loss of consciousness ❑ Diagnosis of failure to thrive or dehydration ❑ From an external care facility ❑ Unable to administer own medications ❑ Previous hospital admission in the last week ❑ Confusion ❑ Caregiver unavailable or admitted	❑ Utilizes Community Care Service ❑ In home nursing ❑ Cardiac Rehab ❑ Homemaker ❑ Meals on Wheels ❑ Physiotherapy ❑ Other _____ ❑ Does the patient identify problem with obtaining prescriptions/medical supplies if they become part of the recommended treatment.

Category 2 − Discharge Planning must be notified if any two or more of the following apply to this patient

❑ Lives Alone ❑ Limited or no help to meet needs at home ❑ Uses a mobility device ❑ Urine or stool incontinence	❑ Feels unsafe in home environment ❑ Age over 65 ❑ 2 or more chronic illnesses ❑ 6 or more prescription medications

Referred to Discharge Planning ❑ Yes ❑ Not required−patient does not meet Category 1 / 2 Criteria

Who will come to get you and take you home? _____
How do you contact this person? _____

Is there anything else that we should know about you to assist in planning your care? _____

_____

Signature/Status _____ Date (dd/mm/yyyy) _____

Signature/Status _____ Date (dd/mm/yyyy) _____

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NUR3

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