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 ________ O₂ sat ________ R/A ______
Height ________ Weight ________ (lb / Kg) ☐ Taken ☐ Stated ☐ Updated in OE ☐ O₂ @ ______ via ______

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 hospital: ☐ 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, Oxydodone) ☐ 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 Cut down on your drinking (or drug use)? ☐ Yes ☐ No
2. Have people Annoyed you by criticizing your drinking (or drug use)? ☐ Yes ☐ No
3. Have you ever felt bad or Guilty about your drinking (or drug use)? ☐ Yes ☐ No
4. Have you ever had a drink (or used drugs) first thing in the morning (Eye−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)
#### 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

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

#### Apical Pulse
- _____ min.

#### Peripheral Pulses
- Radial
- Pedal
- Edema
- Calf Tenderness
- Pacemaker

#### Gastrointestinal Assessment
- Abd. Soft: non–tender; Bowel sounds present in all 4 quadrants. Absence of Nausea/vomiting; normal BM's within own pattern
- i) Date of last BM (dd/mm/yyyy)
- ii) Pt’s usual pattern

#### Bowel sounds (circle location)
- Absent
- Diminished
- Hyper
- Describe

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

#### Fluid Site
- Type
- Site
- Solution
- Rate
- Amt TBA

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

#### Temperature
- Cool
- Hot
- Diaphoretic
- Red/Inflamed
- Jaundiced
- Pallor

#### Other comments ____________________________

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**Fam:** Israel, Robert W.  
**Svc/AdmDate:** 09/01/2006  
**Test, Patient:** A  
**Test Patient:** A  
**F.R.N:** 09/01/2006  
**Test, Patient:** A  
**OCP:** A7770020  
**MM#:** 555−44−2223  
**Att:** Welby, Marcus  
**Fam:** Israel, Robert W.  
**Svc/AdmDate:** 09/01/2006  
**Test, Patient:** A  
**OCP:** A7770020  
**MM#:** 555−44−2223  
**Att:** Welby, Marcus  
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**Chart Copy Do Not Destroy**
**Admission Data Base**

**(Medical/Surgical)**

### Wound/Incision Dressing Assessment
- Incision clean, dry, intact with no tenderness; sutures/staples/Steri-Strips intact; (specify location if more than 1)
- Drainage (amt/colour/odour) __________ 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: Person __________ Place __________ Time __________
- Dizzy __________ Sedated __________ Blurred Vision __________ Numbness __________ Other Comments
- Lethargic __________ Seizures __________ 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: Kept, Disheveled, Soiled, Body odour, Underdressed, Overdressed, Bizarre
  - Affect(mood): Euphoric, Elevated, euthymic(normal mood), Despondent, Depressed
  - Anxiety: Calm, Tense, Anxious, Fearful, Panicked, Agitated, Irritable, Angry
  - Behavior:
    - Movements: Normal, Hypokinetic, Hypoactive
    - Organization: Organized, Distractibility, Incoherent/disorganized
    - Purpose: Goal-oriented, Cooperative, Uncooperative, Bizarre
    - 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
- 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: __________
### Admission Data Base
(Medical/Surgical/Critical Care)

<table>
<thead>
<tr>
<th>Activity/Rest</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No sleep disturbances; Verbalizes activity is adequate</td>
<td>❑ Insomnia  ❑ Fatigue  ❑ Inactive Life Style  Other comments:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADL Functional Assessment</th>
<th>Independent  Needs Assistance  Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Independently able to perform self−grooming activities without difficulty; Able to feed self, requires no assistance with tray set−up;</td>
<td>Eating  Bathing  Dressing  Toileting  Communication needs</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Nutrition</th>
<th></th>
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<tbody>
<tr>
<td>❑ 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.</td>
<td>❑ 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:</td>
</tr>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>❑ No hearing/visual/oral deficits</td>
<td>❑ Hearing aid  ❑ Rt ❑ Lt  ❑ Glasses  ❑ At all times ❑ Reading  ❑ Legally Blind ❑ Rt ❑ Lt  ❑ Contact lens</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Teeth:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Caps ❑ Loose teeth ❑ Bridge ❑ Permanent ❑ Partial ❑ Braces</td>
<td></td>
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<tbody>
<tr>
<td>❑ Upper ❑ Partial ❑ Full ❑ Lower ❑ Partial ❑ Full</td>
<td></td>
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### 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
- ❑ Does the patient identify problem with obtaining prescriptions/medical supplies if they become part of the recommended treatment.

### Category II – 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? ____________________________

_________________________________________  Date (dd/mm/yyyy) ____________________________

_________________________________________  Date (dd/mm/yyyy) ____________________________