NURSES' ADMISSION ASSESSMENT

(To be completed within 48 hours of admission to facility)

ADMISSION DATE:_____ **TIME:**_____ ❍ AM ❍ PM **ADMITTED FROM:**_____

Transported via: ❍ Ambulance ❍ Private Car/Vehicle Accompanied by:_____

ADMITTING DIAGNOSES:_____

❍ NKA ❍ Allergies: ❑ Food:_____ ❑ Drug:_____ ❑ Other:_____

Mental Status
❍ Alert/oriented
❍ Comatose
❑ Confused, follows directions
❑ Confused, cannot follow directions
❑ Aphasic
❑ Depressed/sad
❑ Memory loss
❑ Resists care
❑ Indicators of delirium
❑ Other:_____

Vision Status	R	L	Both
Adequate	❍	❍	❍
Adequate w/aid	❍	❍	❍
Poor	❍	❍	❍
Blind	❍	❍	❍
Hearing Status	**R**	**L**	**Both**
Adequate	❍	❍	❍
Adequate w/aid	❍	❍	❍
Poor	❍	❍	❍
Deaf/total loss	❍	❍	❍

Functional Status	Indep	Super-vision/ Setup	Assist	Dep
Bed mobility	❍	❍	❍	❍
Transfer/standing	❍	❍	❍	❍
Walking	❍	❍	❍	❍
Toileting	❍	❍	❍	❍
Personal hygiene	❍	❍	❍	❍

❍ Own teeth ❍ Dentures: ❍ Upper ❍ Lower ❍ Both Condition of mouth and gums:_____

❍ No speech problems ❍ Speech problems, specify:_____

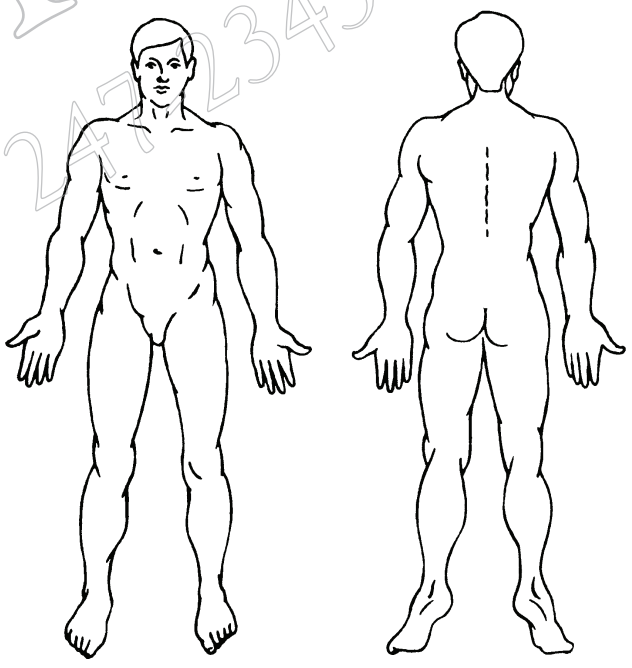
❍ Does not wear glasses ❍ Wears glasses ❍ Other visual appliance(s) used:_____

PERRLA: ❍ No, specify:_____ ❍ Yes

SKIN STATUS

Record location and identify all body marks, such as old or recent scars, bruises or discolorations (regardless of how slight), lacerations, skin ulcers/injuries, wounds, other ulcerations, tattoos and markings considered other than normal:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____



General Skin Condition: ❑ Warm ❑ Dry ❑ Moist ❑ Scaly ❑ Reddened ❑ Oily ❑ Cyanotic ❑ Pale ❑ Other:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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VITAL SIGNS

(Record each shift for 48 hours after admission) Temp Routes: O = Oral; R = Rectal; T = Tympanic

Date:__________ **Time:**_______ ❍ AM ❍ PM T_______ ❍ O ❍ R ❍ T P______ AP______ R______ BP_____/_____ ❍ Lying ❍ Sitting ❍ Rt Arm ❍ Lt Arm

Date:__________ **Time:**_______ ❍ AM ❍ PM T_______ ❍ O ❍ R ❍ T P______ AP______ R______ BP_____/_____ ❍ Lying ❍ Sitting ❍ Rt Arm ❍ Lt Arm

Date:__________ **Time:**_______ ❍ AM ❍ PM T_______ ❍ O ❍ R ❍ T P______ AP______ R______ BP_____/_____ ❍ Lying ❍ Sitting ❍ Rt Arm ❍ Lt Arm

Date:__________ **Time:**_______ ❍ AM ❍ PM T_______ ❍ O ❍ R ❍ T P______ AP______ R______ BP_____/_____ ❍ Lying ❍ Sitting ❍ Rt Arm ❍ Lt Arm

Date:__________ **Time:**_______ ❍ AM ❍ PM T_______ ❍ O ❍ R ❍ T P______ AP______ R______ BP_____/_____ ❍ Lying ❍ Sitting ❍ Rt Arm ❍ Lt Arm

Date:__________ **Time:**_______ ❍ AM ❍ PM T_______ ❍ O ❍ R ❍ T P______ AP______ R______ BP_____/_____ ❍ Lying ❍ Sitting ❍ Rt Arm ❍ Lt Arm

Height:_________ **Weight:**_______ ❍ Lb ❍ Kg Scale used: ❍ Standing ❍ WC ❍ Lift ❍ Other:________________

BOWEL/BLADDER

Continent of bowel: ❍ No ❍ Yes Comments:________________________________

❑ Uses toilet ❑ Uses commode ❑ Pads ❑ Briefs ❑ Other:________________________________

Date of last BM:____________ BM consistency:______________________________ Blood in stool: ❍ No ❍ Yes

Comments:________________________________

Bowel sounds: ❍ Normal ❍ Hyperactive ❍ Hypoactive ❑ RUQ ❑ RLQ ❑ LUQ ❑ LLQ

Comments:________________________________

Mark all that apply: ❑ Constipation ❑ Diarrhea ❑ Uses laxatives ❑ Uses enemas ❑ Uses stool softener

Comments:________________________________

Continent of bladder: ❍ No ❍ Yes Comments:________________________________

❑ Uses toilet ❑ Uses commode ❑ Uses urinal/bedpan ❑ Pads ❑ Briefs ❑ Other:________________

Color of urine:________________ Frequency of voiding:____________________ Wakes to toilet: ❍ No ❍ Yes

Comments:________________________________

Indwelling catheter in place: ❍ No ❍ Yes, reason/diagnosis:________________________________

Date inserted/last changed:____________ Size/type:________________________________

Color of urine:__________________ ❍ Clear ❍ Cloudy ❍ Blood in urine ❑ Other:________________

Ostomy: ❍ No ❍ Yes, specify location and surrounding skin status:________________________________

LUNGS/CHEST

Lungs clear to auscultation: ❍ No, specify:________________________________ ❍ Yes

Heart rate: ❍ Regular ❍ Irregular ❑ Murmur heard Comments:________________________________

Pacemaker present: ❍ No ❍ Yes Comments:________________________________

EXTREMITIES

Full active ROM: ❑ Upper extremities ❑ Lower extremities

Comments:________________________________

Contractures present: ❍ No ❍ Yes, specify location and severity:________________________________

Edema present: ❑ RLE ❍ Non-pitting ❍ 1+ ❍ 2+ ❍ 3+ ❍ 4+ Other:________________

❑ LLE ❍ Non-pitting ❍ 1+ ❍ 2+ ❍ 3+ ❍ 4+ Other:________________

❍ No edema present in either lower extremity

Uses TED hose/compression stockings: ❍ No ❍ Yes, specify:________________________________

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

NURSES' ADMISSION ASSESSMENT

PAIN

Experiencing pain at present: ❍ No ❍ Yes, specify location and duration:_____

_____

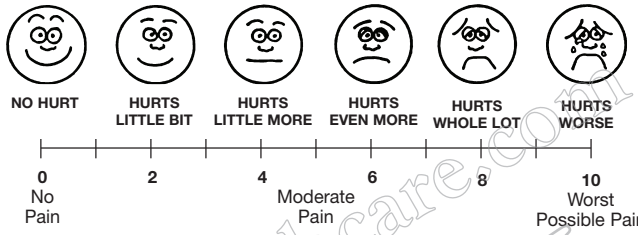
Describe: ❑ Aching ❑ Heavy ❑ Tender ❑ Splitting ❑ Tiring ❑ Exhausting ❑ Throbbing ❑ Shooting ❑ Stabbing ❑ Sharp ❑ Cramping ❑ Hot/burning ❑ Tingling ❑ Other:_____

Additional symptoms associated with pain (i.e., nausea, anxiety):_____

Pain increased by (describe circumstances or activities):_____

_____

Wong-Baker FACES Pain Rating Scale



**From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Resident's rating of pain:_____

Frequency of pain: ❍ Constant/almost constant ❍ Frequently ❍ Occasionally ❍ Rarely ❍ Unable to answer

Does pain interfere with daily activities: ❍ No ❍ Yes, specify:_____

_____

SLEEP

Difficulty falling asleep: ❍ No ❍ Yes What helps to fall asleep:_____

Difficulty staying asleep: ❍ No ❍ Yes What helps to go back to sleep:_____

Preferred time to awaken/rise:_____ Preferred time to retire:_____

Naps during daytime: ❍ No ❍ Yes What time(s) are naps preferred:_____

Uses sleeping medication: ❍ No ❍ Yes, specify:_____ ❍ Prescription ❍ OTC

Identify sleeping aids/preferences, i.e., window open, night light, music, etc.:_____

_____

LIFESTYLE

Uses tobacco: ❍ No ❍ Yes, specify:_____ How much/day:_____ How often:_____

Comments:_____

Uses alcohol: ❍ No ❍ Yes, specify:_____

Primary language: ❍ English ❍ Spanish ❍ Other, specify:_____

Interpreter needed: ❍ No ❍ Yes Comments:_____

Residence before admission to this facility: ❍ Home ❍ Assisted Living ❍ Another LTC facility ❍ Other:_____

Resident lived alone: ❍ No ❍ Yes Comments:_____

Resident wishes to return to prior residence: ❍ No ❍ Yes Comments:_____

Attitude towards admission to this facility:_____

Attitude towards overall health status/medical issues:_____

Advance Directives: ❍ No ❍ Yes **Wishes to be Resuscitated:** ❍ No ❍ Yes **DNR Order:** ❍ No ❍ Yes

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NURSES' ADMISSION ASSESSMENT

RISK FACTORS

Falls: ❍ No falls prior to admission ❍ Fell in past 30 days ❍ Fell in past 31-180 days ❍ Fall w/major injury in past 180 days

Comments:_____

_____

Wanders/Elopement:

❍ No history of wandering/elopement ❍ Has wandered/left residence in past

Comments:_____

_____

Depression: ❍ No ❍ Yes

Expressed thoughts of suicide or being better off dead: ❍ No ❍ Yes

Comments:_____

_____

MEDICATIONS

Medication Reconciliation complete: ❍ No ❍ Yes Location in medical record:_____

PRIOR FUNCTIONING/DEVICE USED

Prior Functioning – Everyday Activities: Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation or injury. (Enter codes in boxes)

Coding:

3. **Independent** - Resident completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete activities.
1. **Dependent** - A helper completed the activities for the resident.
8. **Unknown**
9. **Not Applicable**

☐ **A. Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.

☐ **B. Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

☐ **C. Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.

☐ **D. Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Prior Device Use: Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury. (Check all that apply.)

❑ Manual wheelchair ❑ Motorized wheelchair and/or scooter ❑ Mechanical lift ❑ Walker
❑ Orthotics/prosthetics ❑ None of the above

ADDITIONAL NOTES

_____

_____

_____

_____

_____

SIGNATURE/DATE

Nursing Admission Assessment Completed By:_____ **Date:**_____
Signature/Title

Nursing Admission Assessment Completed By:_____ **Date:**_____
Signature/Title

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed