

ADMISSION NURSING ASSESSMENT

STATUS UPON ADMISSION

Admission Notes		Allergies
Date of admission <u>1/1</u> a.m. p.m.		Meds _____
Transported by _____		Food _____
Accompanied by _____		Other _____
Age _____ Sex _____ Weight _____ Height _____ Ft _____ In _____		
Vitals: T _____ P _____ (<input type="checkbox"/> Reg <input type="checkbox"/> Irreg) R _____ B/P _____		
Attending physician notified? <input type="checkbox"/> No <input type="checkbox"/> Yes, date/time _____	a.m. p.m.	
Diagnosis: _____	Date last chest x-ray or PPD _____	

PAIN

(As described by resident/representative)

Frequency:

No pain Daily, but not constant
 Less than daily Constant

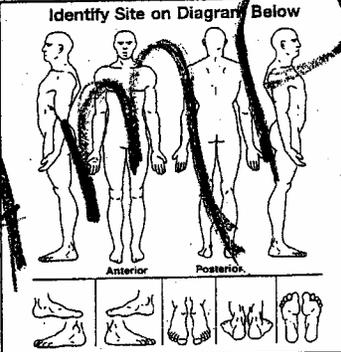
Location: _____

Intensity:

No pain Severe pain
 Mild pain Horrible pain
 Distressing pain Excruciating pain

Pain on admission:

No Yes _____



Skin Condition

Using the diagram provided, indicate all body marks such as old/recent scars (surgical and other), bruises, discolorations, abrasions, pressure ulcers, or questionable markings. Indicate site, depth (in cms), color and drainage.

COMMENTS: _____

SPECIAL TREATMENTS & PROCEDURES:

See Pressure Ulcer Record

CURRENT STATUS

General Skin Condition	Physical Status (describe if applicable, otherwise indicate NA)
Check all that apply	Paralysis/paresis-site, degree _____
<input type="checkbox"/> Reddened <input type="checkbox"/> Pale <input type="checkbox"/> Jaundiced	Contracture(s)-site, degree _____
<input type="checkbox"/> Cyanotic <input type="checkbox"/> Ashen	Congenital anomalies _____
<input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Oily <input type="checkbox"/> Warm <input type="checkbox"/> Cold	Prosthesis: _____
<input type="checkbox"/> Edema, site _____	Other _____

Functional Status

TRANSFERS-ABLE TO TRANSFER	AMBULATION-ABLE TO AMBULATE	SUPPORTIVE DEVICES USED:
<input type="checkbox"/> Independently	<input type="checkbox"/> Independently	<input type="checkbox"/> Elastic hose <input type="checkbox"/> Footboard
<input type="checkbox"/> 1 person assist	<input type="checkbox"/> 1 person assist	<input type="checkbox"/> Bed cradle <input type="checkbox"/> Air mattress
<input type="checkbox"/> 2 person assist	<input type="checkbox"/> 2 person assist	<input type="checkbox"/> Sheepskin <input type="checkbox"/> Eggcrate
<input type="checkbox"/> Total assist	<input type="checkbox"/> With device	<input type="checkbox"/> Hand rolls <input type="checkbox"/> Sling <input type="checkbox"/> Trapeze
WEIGHT BEARING-ABLE TO BEAR	Type _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Full weight	<input type="checkbox"/> Wheelchair only	<input type="checkbox"/> Other _____
<input type="checkbox"/> Partial weight	<input type="checkbox"/> Wheelchair/propels self	
<input type="checkbox"/> Non-weight bearing	<input type="checkbox"/> Bedrest	

Drug Therapy

DRUG	DOSE/FREQUENCY	DRUG	DOSE/FREQUENCY
1		6	
2		7	
3		8	
4		9	
5		10	

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

