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ASSESSMENT PARAMETERS	ASSESSMENT AREAS
NEUROLOGICAL: Alert. Oriented to Person, Place, Time. Behavior appropriate. Pupils Equal & reactive to light. Active ROM of all Extremities w/symmetry of strength. No paresthesia. Vocalization clear & understandable. Swallows without coughing or choking on solids or liquids. □ WNL □ WNL EXCEPT FOR:	__Responds to Voice ___Responds to Pain ___Unresponsive Oriented: ___ Person ___ Place ___ Time ___ None Pupils: ____ Other R_____ L_____ MAE: R Arm____ L Arm____ R Leg____ L Leg____ ____ Other:_____ ____Speech: ____ Slurred ____Aphasic ____Dyphagia:_____ Other:_____ _____ ___SEE NURSING NOTES
INTEGUMENTARY: Skin color within patient's norm. Skin warm, dry, & intact. Mucous Membranes moist. BRADEN SCALE SCORE GREATER THAN 16 (see attached scoring sheet for parameters) BRADEN SCALE SCORE:_____ (See BRADEN Chart below) □ WNL □ WNL EXCEPT FOR:	Skin color:___Pale ___Flushed ___Cyanotic ___Other:_____ Skin: ___Cold ____Hot ____Dry ___Moist ___Diaphoretic BRADEN SCALE SCORE ___Mucous Membranes: ____Dry Other (specify):_____ _____ _____ ___SEE NURSING NOTES IV:____Patent/Nonphlebitic Site:_____

BRADEN SCALE for predicting pressure sore risk. Score of 17 or less at risk for breakdown.

SENSORY PERCEPTION: __1 __2 __3 __4 MOISTURE: __1 __2 __3 __4 ACTIVITY: __1 __2 __3 __4
FRICTION & SHEAR: __1 __2 __3 __4 NUTRITION: __1 __2 __3 __4 MOBILITY: __1 __2 __3 __4
TOTAL BRADEN SCORE:_____

Indicate any body markings:
A – Abrasion
B – Burn
C - Contusion
D – Pressure Ulcer
Ec – Ecchymosis
Er – Erythema
H – Hematoma
L – Laceration
Le – Lesion
P – Petechiae
R – Rash
S – Scar
O – Other (specify) _____
_____
_____
___SEE NURSING NOTES

CARDIOVASCULAR: Regular Apical pulse. Peripheral pulses palpable. No edema, no calf tenderness. . □ WNL □ WNL EXCEPT FOR:	Apical Pulse: ___Irregular ___Tachycardia ___Bradycardia Peripheral Pulses Other:_____ Edema:_____ ___Right Calf Tender ___Left Calf Tender ___Tele_____ Comments:_____ _____ ___SEE NURSING NOTES

PULMONARY - Respiratory rate at 10-20 per minute at rest. - Respirations quiet & regular - Breath sounds clear throughout all lung fields. - Nailbeds & Mucous membranes pink - No Home Respiratory Therapy □ WNL □ WNL EXCEPT FOR:	IF ANY AREA CHECKED HERE, NOTIFY RESPIRATORY SERVICES (See Below). Right Lung __Wheeze __I __E __Rhonchi __Crackles(Rales)_<BS Left Lung __Wheeze __I __E __Rhonchi __Crackles(Rales)_<BS Resp. Labored: ___Yes ___No Cyanosis: ___Lips ___Nailbeds Cough: ___Nonproductive ___Strong ___Weak ___Productive (Sputum color/consistency):_____ O_2 Sat____% on ___Room Air ___L/min O_2 via_____ ___Trache Home Resp. Care:__ O_2 __MDI's___Nebulizer____BiPap___Other If Other, please specify:_____ COMMENTS:_____ _____ RESPIRATORY SCREENING: ___Abnormal Breath Sounds ___Ineffective cough ___SOB / Labored Breathing ___Home Resp. Care RESPIRATORY REFERRAL: ___Yes ___No Order #_____ SPEECH Therapy REFERRAL: ___Yes ___No Order #_____ ___SEE NURSING NOTES
GASTROINTESTINAL: __ Abdomen soft with Active Bowel Sounds (5-24/min) __No pain with palpation. __Tolerates diet without nausea or vomiting. __BM's within own normal pattern & consistency. □ WNL □ WNL EXCEPT FOR:	Abdomen: __Distended__ Semifirm ___Firm ___Tender (specify):_____ Bowel sounds: ___Absent ___Hyperactive ___Hypoactive Bowel Movements:_____ ___Incontinent ___Colostomy ___Last BM:_____ ___Nausea ___Vomiting (freq/duration)_____ Comments:_____ _____ _____ ___SEE NURSING NOTES
GENITOURINARY: Able to empty bladder without dysuria. Bladder not distended after voiding. Urine clear & yellow to amber. □ WNL □ WNL EXCEPT FOR:	Bladder: ___Distended ___Incontinent ___Foley ___Other Dysuria (specify):_____ Urine: ___Cloudy ___Foul odor Other:_____ Comments:_____ _____ ___SEE NURSING NOTES
MUSCULOSKELETAL: Absence of joint swelling & tenderness. Normal ROM of all joints. No muscle weakness. □ WNL □ WNL EXCEPT FOR:	___ROM Restricted (specify):_____ ___Pain (specify):_____ Muscles: ___Weakness Specify:_____ ___Joints w/swelling_____ Other:_____ Comments:_____ _____ ___SEE NURSING NOTES

_____Date/Time:_____ RN signature

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ADMISSION ASSESSMENT

ACTIVITIES OF DAILY LIVING:

	Independent	Devices used	Help or supervision	Totally dependent
Eating				
Bathing				
Dressing				
Ambulation				
Transferring				

BP_____ **P**_____ **R**_____ **SaO2**_____

HEIGHT_____**WEIGHT**_____**(Actual/Estimated)**
Reason for admission:_____

_____

Admitted from: _____home _____nsg facility
_____emergency _____other

ALLERGIES:

drug ☐ NKA_____
_____reaction:_____
food ☐ NKA_____
_____reaction:_____
latex ☐ NKA_____
_____reaction:_____

PSYCHOSOCIAL:

Lives: ☐ alone ☐ with_____
Living conditions:
Hea t ☐ Yes ☐ No Source:_____
Water/sewer ☐ Yes ☐ No

COMMUNICATION:

Primary language: ☐ English ☐ Other_____
Method of communication: ☐ Verbal ☐ Written
☐ Sign ☐ Other _____

PREFERRED METHOD OF LEARNING:

☐ 1:1 ☐ TV ☐ Handouts
Able to read: ☐ Yes ☐ No

HEALTH HISTORY:

TB ☐ COPD ☐ CHF ☐ Asthma ☐
Hepatitis ☐ Diabetes ☐ Seizures ☐
Cancer ☐ Hypertension ☐

_____

_____

_____

_____

Past surgeries:_____

_____

Immunizations: Pneumonia:_____

Tetnus:_____ Influenza:_____

CURRENT MEDICATIONS:

Name	Dose	Frequency	Last Dose

MEDS DISPOSITION:

☐ home with _____
☐ pharmacy
☐ other _____

Tobacco use: ☐ yes ☐ no Amount _____

Alcohol: ☐ yes ☐ no Amount _____

Drug use – street or legal_____

VISION:

☐ Glasses ☐ Contacts ☐ Other_____

HEARING:

☐ Hard of Hearing
☐ Hearing aid ☐ LT ☐ RT ☐ Both

DENTITION:

☐ Own teeth intact ☐ Yes ☐ No
☐ dentures ☐ upper ☐ lower ☐ both
☐ capped teeth _____
☐ other_____
Difficulty chewing ☐ Yes ☐ No
Difficulty swallowing ☐ Yes ☐ No

COGNITIVE:

☐alert ☐oriented ☐anxious ☐agitated ☐lethargic
☐ disoriented/confused ☐ withdrawn ☐ comatose
☐ Other_____

Information given by:_____
Patient//Family member/Significant Other

_____
NA/LPN/RN Signature

ORIENTATION

Item Explained	Date	Item Explained	Date
Nurse Call Light		Siderails	
Bed Controls		Bathroom (I & O)	
Safety Precautions		No Smoking Policy	

VALUABLES CHECK-LIST

	Admit	Discharge	Comments
Dentures			
Glasses			
Contact Lenses			
Jewelry – specify			Valuables envelope #
Purse/wallet			
Own medications			

LMH does not accept responsibility for the above items.

Signature_____

Witness_____

All items listed above have been returned to the patient and/or family._____

SIDE RAIL RELEASE

It is my preference to have the siderails:

Both Up_____

Both Down _____

Both ½ Up _____

One down/One up _____

No Preference _____

_____

Patient Signature

DISCHARGE PLANNING (initial)

Assessment by Discharge Planner_____

Identify Support Systems_____

Referral:□Home Health/Home Care □Home with Assist

Goal:□ Return Home □ Home with Assist

□ Skilled Nursing Facility □ Long-term care

DISCHARGE NOTES

(If yes address in additional notes)

Medical limitations:	Yes □	No □
Functional limitations:	Yes □	No □
Psychological limitations:	Yes □	No □
Emotional limitations:	Yes □	No □
Social limitations:	Yes □	No □
Financial limitations:	Yes □	No □
Education received:	Yes □	No □
Referalls:	Yes □	No □

Discharged to:_____

Significant other/Caretaker:_____

Condition at discharge:_____

MEDICATIONS AT DISCHARGE:

See Discharge Instructions

DIET:_____

A.D.L.S. Changes from admission Yes □ No □

_____

FOLLOW-UP:_____

_____

TREATMENTS:_____

DIABETIC:_____

_____

TRANSPORTATION:_____

Signature:_____

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DAILY ROUTINES and ACTIVITIES:

Morning:_____

_____

_____

_____

Afternoon:_____

_____

_____

_____

Evening:_____

_____

_____

_____

Night:_____

_____

_____

Information Provided by: _____
Patient/Family or Significant Other

Signature:_____
RN/LPN/ NA