PATIENT'S FUNCTIONAL SCREENING / RISK ASSESSMENTS

IDENTIFY NEEDS FOR CARE
(RN Only)

PATIENT LABEL

FUNCTIONAL SCREENING (✓ APPROPRIATE BOX)

(For Patients 13 Years or Greater Assess All Screens / Risk Assessments)

CURRENT FUNCTIONING AT TIME OF ADMISSION	Completely Independent	Independent With Assistive Device	Requires Assistance Person	Requires Assistance Person & Devices	Dependent Does Not Participate
1. Transferring (PT)					
2. Ambulation (PT)					
ANY RECENT DECLINE IN MOBILITY, CONSIDER REQUESTING A P.T. CONSULT FROM THE PHYSICIAN.					
3. Bathing (OT)					
4. Dressing (OT)					
5. Toileting (OT)					
6. Feeding (OT)					
ANY RECENT DECLINE IN PERFORMANCE OF ADL'S CONSIDER REQUESTING AN O.T. CONSULT FROM PHYSICIAN.					
	EFFECTIVE	INEFFECTIVE			
7. Communication (SP)					
8. Swallowing (SP)					
If other than effective, request Speech Pathology (SP) consult from Physician.					

PATIENT SAFETY & PROTECTION RISK ASSESSMENT

RISK PARAMETERS / FACTORS	YES	NO
1. Confused / Disoriented / Hallucinating		
2. Balance / Gait Disorder		
3. Muscle Strength Deficits		
4. Behavior Harmful to Self, Others (Caregivers, Visitors)		
5. Taking Medications That Are Associated With Increasing Risk For Falls. (i.e. Analgesics, Antihypertensive, Cardiac Drugs or Psychotropic Medications)		
6. Recent History of Falling		
7. Age 70 or older		
8. Drug/Alcohol Withdrawal		
9. Sensory Limitations		
10. Routine Use of Orthopedic Device		
11. Altered Elimination (Incontinence, Frequency, Nocturia)		

*** If any of these risk parameters are present, place patient on falls precautions and evaluate need for additional safety/protection intervention. Apply Fall Precaution wrist band.**

(based on Hendrich/Nyhuis Fall Risk Model)

SKIN INTEGRITY RISK ASSESSMENT

CRITERIA	0	1	2	3	SCORE
MOBILITY	COMPLETELY INDEPENDENT	SLIGHTLY LIMITED	VERY LIMITED	IMMOBILE	
MENTAL STATUS	ALWAYS ALERT	CONFUSED AT TIMES	COMPLETELY CONFUSED	LETHARGIC / COMATOSE	
NUTRITIONAL STATUS	GOOD - EATS 75% OF MEAL	FAIR - EATS 50 - 74% OF MEAL	POOR EATS < 50% OF MEAL	TUBE FEEDING / PARENTERAL REQUIRED	
GENERAL SKIN CONDITION	GOODTURGOR	ABRASIONS OR RASHES	POORTURGOR / EDEMA / ERYTHEMA	DRY / ATROPHIC	
INCONTINENCE	NONE	URINARY	FECAL	URINARY & FECAL	
GENERAL PHYSICAL CONDITION	GOOD	FAIR	POOR	BAD	
(BASED ON NORTON SCALE)					TOTAL

NURSING INTERVENTIONS
SCORE OF 0-9 = LOW RISK - ROUTINE NURSING CARE
SCORE OF 10-18 = HIGH RISK - SEE PROTOCOL.

SOCIAL HISTORY

PATIENT LABEL

1. Where do you live? ( ) House ( ) Apartment (Floor) ____________ ( ) Trailer ( ) Retirement Facility
   ( ) Nursing Home Name: ______________________
2. Contact Person: Name ______________________ Relationship ______________________
   Phone (Home) ______________ (Work) ______________ Phone (Cell) ______________

ABUSE SCREENING

1. Does patient's appearance demonstrate poor hygiene, malnutrition and/or dehydration? ( ) Yes ( ) No
2. Does patient appear frightened or intimidated in presence of caregiver? ( ) Yes ( ) No
3. Does patient have unexplained bruises, lacerations, abrasions, head injuries, burns, sprains or fractures? ( ) Yes ( ) No

*** If any of the following boxes are checked or if you anticipate special help after discharge initiate the appropriate referrals below.**

HIGH RISK ASSESSMENT FOR DISCHARGE PLANNING AND SOCIAL SERVICE INTERVENTION: (check all appropriate boxes that apply)

____ LIVES ALONE OR WITH NONCAPABLE CAREGIVER	____ PREGNANCY; HIGH RISK / COMPLI-CATED PREGNANCY; SINGLE PARENT UNDER AGE OF 17; ADOPTION	____ HX CHRONIC RENAL FAILURE / CHF
____ NO KNOWN PLACE OF RESIDENCE / HOMELESS	____ CURRENTLY USING A HOME CARE AGENCY	____ (NEW) CABG DIAGNOSIS
____ AGE 75 YEARS OR OLDER	____ HX OF FORGETFULNESS OR CONFUSION	____ END STAGE CARDIOMYOPATHY
____ FROM NURSING HOME OR INTERMEDIATE CARE FACILITY	____ HEAD / SPINAL CORD INJURY	____ TERMINAL ILLNESS
____ READMISSION WITHIN 30 DAYS	____ JOINT REPLACEMENT / AMPUTEE / FRACTURE	____ NEW OSTOMY
____ ACTIVE SUBSTANCE ABUSE	____ HIV DIAGNOSIS	____ DEHYDRATION; POOR NUTRITIONAL STATUS
____ DRUG OVERDOSE / ATTEMPTED SUICIDE	____ CVA DIAGNOSIS	____ HX OF MENTAL RETARDATION
____ SUSPECTED ABUSE / NEGLECT	____ STAGE 2-4 PRESSURE ULCER	____ USE HOME HEALTH AGENCY
____ NO IDENTIFICATION - JOHN / JANE DOE	____ PEG TUBE INSERTION	____ MEALS BROUGHT IN
____ FAMILY / DOMESTIC PROBLEMS	____ NEW DIALYSIS	____ USE HOME OXYGEN
____ ADOLESCENT BEHAVIOR / SOCIAL PROBLEMS		____ ADULT DAY CARE
		____ USE HOMEMAKER SERVICE
		____ TUTOR NEEDED
		____ PATIENT IN FOSTER CARE SYSTEM

REFERRAL RECOMMENDATIONS	REFERRALS MADE
( ) No Referrals At This Time	( ) Social Service Notified
( ) Social Service / Discharge Planning Needed	( ) Dietitian Notified
( ) Nutritional Consult Needed	( ) Spiritual Care Notified
( ) Spiritual Care Needed / Assist with Adv. Directives	( ) Home Health / Hospice Referral Made (Circle One)
( ) Home Health / Hospice Referral Indicated	( ) Pharmacist Notified
( ) Pharmacist Referral Needed	( ) *Rehabilitation Referral Services Made – **DOCTOR ORDER WRITTEN**
( ) *Rehabilitation Services Needed – **DOCTOR ORDER REQUIRED**	☐ Physical Therapy
☐ Physical Therapy	☐ Occupational Therapy
☐ Occupational Therapy	☐ Speech Therapy
☐ Speech Therapy	

Referrals Entered By: ______________________ Date ______________

ADMISSION ASSESSMENT

PATIENT LABEL

ADM. DATE ________ ADM. TIME ________ PRIMARY PHYSICIAN ______________________

MODE OF ADMISSION: AMBULATORY ( ) STRETCHER ( ) WHEELCHAIR ( )

INFORMANT: ______________ LANGUAGE SPOKEN: ______________________

TO BE COMPLETED ON ALL ADMITTED PATIENTS

HT. ________ WT. ________ (lb) - Actual T: (O,R,A,TYM) ________ AP ________ Radial ________ BP: R ________ L ________ RESP. ________

ALLERGIES (Refer to admission order form)

PATIENT HISTORY

Chief Complaint:

Previous Hospitalization:

PAIN ASSESSMENT

☐ NO PAIN NOW
☐ PAIN NOW / RECENT PAST

Pain Level at present:

What number is acceptable to you?

Scale Used
☐ 0 - 10
☐ Faces
☐ FLACC

Location of Pain: (see Scale)

Type of Discomfort: (see Scale)

Comfort Strategies used to treat pain:

LOCATION:
1 = Head
2 = Chest
3 = Breast
4 = Abdomen
5 = Back
6 = Extremity
7 = Uterine
8 = Perineum
9 = Surgical/Incision
10 = Joint
11 = Generalized
12 = Other

TYPE OF DISCOMFORT:
1 = Aching
2 = Acute
3 = Burning
4 = Chronic
5 = Contractions
6 = Cramping
7 = Crushing
8 = Dull
9 = Heavy
10 = Intermittent
11 = Nausea/Vomiting
12 = Radiating
13 = Sharp
14 = Stabbing
15 = Tender
16 = Throbbing
17 = Other

DO YOU USE ANY ALTERNATIVE THERAPY? ( ) Yes ( ) No Describe:

PATIENT BELONGINGS (✓) CHECK ALL THAT APPLY

✓ = YES	PATIENT	GIVEN TO FAMILY	GIVEN TO SECURITY	✓ = YES	PATIENT	GIVEN TO FAMILY	GIVEN TO SECURITY
DENTURES Upper Lower Both				JEWELRY (DESCRIBE)			
HEARING AID - R / L							
GLASSES / CONTACTS				CLOTHING (LIST)			
PROSTHESIS / BRACE							
MONEY (AMT.)				OTHER:			
KEYS				✓ = YES	LEFT AT HOME	LOCK IN PATIENT MED BOX	GIVEN TO FAMILY
WATCH				MEDICATIONS			

I/we take full responsibility for retaining in my possession the articles listed above and any other articles brought to me while a patient at St. Francis Hospital.

Patient or Family Signature ______________________ Date ______________
Patient unable to sign/Family not present ☐ Date ______________

PT/SIGNIFICANT OTHER ORIENTED TO

( ) Initial Plan of Care
( ) Call Light
( ) Bed Control
( ) Bathroom / Emergency Call Light
( ) Telephone
( ) Television

RN Signature ______________________ Date ________
RN Signature ______________________ Date ________

PATIENT LABEL

MEDICAL HISTORY / SYSTEM REVIEW/ NUTRITIONAL SCREENING

DOES THE PATIENT HAVE A HISTORY OF:	YES	NO
A. CARDIOVASCULAR		
1. Chest Pains/Angina/Tightness/Burning (Circle One)	☐	☐
2. Heart attack	☐	☐
3. Short of Breath	☐	☐
4. High blood pressure	☐	☐
5. Palpitations	☐	☐
6. Pacemaker	☐	☐
7. Heart Murmur/Mitral Valve Prolapse	☐	☐
8. Congenital Heart Defect	☐	☐
9. Rheumatic Fever	☐	☐
10. Do you have a family history of any of the above?	☐	☐
B. RESPIRATORY		
1. Tuberculosis/Positive Skin Test	☐	☐
2. Persistent Cough	☐	☐
3. Asthma	☐	☐
4. Productive Cough	☐	☐
5. Bronchitis/Pneumonia/Emphysema (circle one)	☐	☐
6. Have you had a Pneumonia vaccine (Pneumovax) in the last 10 years?	☐	☐
7. Have you had a flu shot this year?	☐	☐
8. Cold within the past 2 weeks	☐	☐
9. Do you smoke? Packs/Day _______ How many years? _______	☐	☐
10. Have you ever smoked?	☐	☐
11. Does anyone at home smoke?	☐	☐
12. Patient/Family directed to smoking cessation info	☐	
C. NEUROLOGICAL		
1. Blackout Spells/Dizziness	☐	☐
2. Stroke	☐	☐
3. HX of Seizures	☐	☐
4. Paralysis of an extremity	☐	☐
5. Loss of Balance	☐	☐
6. Abnormal sensation in your arms or legs?	☐	☐
7. Frequent Headaches?	☐	☐
8. Chronic Sleeping Problems	☐	☐
9. Do you have a family history of any of the above?	☐	☐
D. ENDOCRINE / OTHER		
1. Diabetes	☐	☐
2. Thyroid Trouble	☐	☐
3. Auto Immune Disease	☐	☐
4. High Fevers after Anesthesia	☐	☐
5. Do you have a family history of any of the above?	☐	☐
E. GASTROINTESTINAL		
1. Hx of Stomach or Duodenal Ulcer?	☐	☐
2. Frequent Indigestion/Heartburn?	☐	☐
3. Hiatal Hernia	☐	☐
4. Colostomy	☐	☐
5. Liver Disease	☐	☐
6. Hepatitis	☐	☐
7. Gallbladder Disease	☐	☐
8. Loose or capped teeth	☐	☐
9. Dentures or poor dentition	☐	☐

	YES	NO
F. NUTRITION SCREENING		
1. Poor appetite for >5 days? <50% of usual intake in past 7 days?	☐	☐
2. Recent unintentional weight loss >10 lbs in past month?	☐	☐
3. Diarrhea/Vomiting/Hyperemesis >7 days?	☐	☐
4. Do you receive nutrition through a feeding tube or IV?	☐	☐
5. Do you have open/draining wounds/pressure ulcers?	☐	☐
6. Are a new diabetic?	☐	☐
Generate a DIETITIAN CONSULT through HBOC if the answer is YES to ANY of the above.		
G. EYES, EARS, NOSE & THROAT		
1. Glaucoma or Cataracts (Circle One)	☐	☐
2. Hard of Hearing	☐	☐
3. Nasal Obstruction	☐	☐
4. Spontaneous Nose Bleeds	☐	☐
5. Sleep Apnea	☐	☐
6. Do you have a family history of any of the above?	☐	☐
H. GENITO - URINARY		
1. Kidney, Prostate or Urinary Trouble (Circle One)	☐	☐
2. Frequency, Burning or Incontinence (Circle One)	☐	☐
3. Dialysis (Last Dialysis) _______________	☐	☐
4. Site for Dialysis: _______________	☐	☐
5. Sexually Transmitted Diseases _______________	☐	☐
6. Do you have a family history of any of the above?	☐	☐
7. Heavy Periods	☐	☐
8. Pregnant or is there a chance you might be?	☐	☐
9. Last Menstrual Period: _______________	☐	☐
10. Last Pap Smear Date: _______________ ☐ Unknown	☐	☐
I. HEMATOLOGICAL		
1. Have you rec'd a blood transfusion this past year? When: _______________	☐	☐
2. Anemia/Bleeding Disorder (Circle One)	☐	☐
3. Sickle Cell Anemia or the Trait (Circle One)	☐	☐
4. Hemophiliac	☐	☐
5. Reaction to any Blood Products	☐	☐
6. Do you have a family history of any of the above?	☐	☐
J. MUSCULO - SKELETAL		
1. Arthritis or Gout (Circle One)	☐	☐
2. Problems with your Back or Neck (Circle One)	☐	☐
3. Calf Tenderness	☐	☐
4. History of Broken Bones	☐	☐
5. Prosthesis/Brace	☐	☐
6. Do you have a family history of any of the above?	☐	☐
K. CANCER Type: _______________	☐	☐
L. PSYCHIATRIC		
1. Do you have a history of Emotional/Psychiatric Disorders? Specify: _______________	☐	☐
M. SOCIAL HABITS		
1. Do you consume more than 2 alcoholic beverages a day?	☐	☐
2. Do you use any kind of "street drugs"? Type: _______________	☐	☐
3. Do you have a history of drug or alcohol dependency?	☐	☐

Signature of Person Completing _______________ ( ) Patient ( ) RN ( ) Family Member ( ) PCP ( ) Other

MENTAL STATUS / PHYSICAL ASSESSMENT
(RN Only)

PATIENT LABEL

MENTAL STATUS
( ) Alert
( ) Oriented x 3
( ) Restless
( ) Drowsy
( ) Non-Responsive
( ) Disoriented
( ) Sedated Medicine
( ) Sleeping
( ) Anxious
( ) Responds to commands
( ) Responds to pain only

SKIN
( ) Warm ( ) Pale
( ) Cool ( ) Dusky
( ) Dry ( ) Flushed
( ) Moist ( ) Jaundiced
( ) Cyanotic
( ) Tenting
( ) Petechiae

ORAL MUCOSA
( ) Moist
( ) Dry

BOWEL SOUNDS
( ) Normal
( ) Absent
( ) Hyperactive
( ) Minimal
( ) Passing Flatus

ABDOMEN
( ) Soft
( ) Distended
( ) Firm
( ) Pain (✓ location)
( ) RUQ ( ) LUQ
( ) MID ( ) EPIGASTRIC
( ) RLQ ( ) LLQ

GAIT
( ) Steady
( ) Unsteady
( ) Limp
( ) Prostheses
( ) Assistive Device
( ) Immobile

R	BREATH SOUNDS	L
( )	Clear	( )
( )	Rales	( )
( )	Rhonchi	( )
( )	Diminished	( )
( )	Wheeze	( )
	RETRACTIONS	
( )	None	( )
( )	Suprasternal	( )
( )	Intercostal	( )
( )	Substernal	( )
( )	Clavicular	( )
	NASAL FLARING	
( )	Absent	( )
( )	Present	( )
	PEDAL PULSE	
( )	0 = Absent	( )
( )	1+ = Barely Palpable	( )
( )	2+ = Palpable, Disappears w/Pressure	( )
( )	3+ = Normal	( )
( )	4+ = Bounding	( )

R	EXTREMETIES	L
↑ ↓		↑ ↓
( ) ( )	Warm	( ) ( )
( ) ( )	Hot	( ) ( )
( ) ( )	Cold	( ) ( )
( ) ( )	Mottled	( ) ( )
( ) ( )	Dusky	( ) ( )
( ) ( )	Cyanotic	( ) ( )
( ) ( )	Tender	( ) ( )
( )	Strong Grasp	( )
( )	Weak Grasp	( )
( )	No Grasp	( )
	CAPILLARY REFILL	
( )	0 - 2 sec	( )
( )	> 2 sec	( )
	PUPILS	
( )	Equal	
( )	Not Equal	
( )	Reactive	
( )	Non Reactive	
	PEDAL EDEMA	
( )	0 = Absent	( )
( )	1+ = Mild 0-1/4"	( )
( )	2+ = Moderate 1/2"	( )
( )	3+ = Severe 3/4"-1"	( )

TUBES / DRAINS / OSTOMY / TRACH

	PATENT	DRAINAGE	CLAMPED/ CAPPED
TYPE _________	( ) YES ( ) NO	( ) YES ( ) NO	( ) YES ( ) NO
TYPE _________	( ) YES ( ) NO	( ) YES ( ) NO	( ) YES ( ) NO
TYPE _________	( ) YES ( ) NO	( ) YES ( ) NO	( ) YES ( ) NO
TYPE _________	( ) YES ( ) NO	( ) YES ( ) NO	( ) YES ( ) NO

Venous Access Device / IV:

_____ Not Applicable _____ Hickman _____ Mediport _____ Portacath
_____ PICC _____ Length of Catheter _______________ cm.
_____ Dialysis Access _______________ Type
Site Assessment / Location: _______________

In addition to above, document on all OB PATIENTS

GR _______ T _______ PT _______ AB _______ SB _______ L _______
LMP _______________ EDC _______________
Blood Type _______________
Onset of Labor: Date: _______________ Time: _______________
Abdomen: Soft Rigid Tender to touch _______________
Bloody Show ( ) YES ( ) NO
BOW: Int. Bulg. Rupt. Nitrazine: Pos Neg N/A
When Last Ate: Time: _________ What: _______________
Membranes Ruptured Date: _______________ Time: _______________
Appearance _______________ Odor _______________
Admission Exam: Time: _______________
by whom _______________ Dilation _______________ EFF _______________
CX: Ant. ______ Post ______ Position ______ Station ______
FHT's ______ Breast feed Bottle feed Pediatrician _______________
Specific labs drawn: CBC ______ Serology ______
Chem Profile ______ Type & Screen ______ Hepatitis B Sur Antigen ______
Special Viral Studies ______ ABO & RH Type ______
Drug Assay ______ Protein Dip ______ GBBS ______

In addition to above, document on all patients 0-17 years of age.

Disease Exposure: ( ) Chicken Pox ( ) Measles ( ) Mumps
Immunizations up to date: ( ) OP ( ) MMR ( ) DPT ( ) TINE ( ) HIB
Any recent exposure to contagious disease? ( ) NO ( ) YES
Disease Name: _______________ Exposure Date: _______________

SOCIAL HISTORY:
Grade Level _______________
Siblings: _______________
Sleeping Habits: _______________
Security Object: _______________
Away from home before: _______________
Night Light: ( ) YES ( ) NO

DEVELOPMENT AND DAILY HABITS: (Check if applies)
Crawl ______ Climb ______ Sit ______ Walk ______
Toilet Trained ______ Bedwetter ______ Stand ______ Talk ______
DIET: Breast Milk ______ Bottle ______ Cup ______ Formula ______
Strained ______ Junior ______ Table food ______
APPETITE: Good ______ Fair ______ Poor ______
Feeds Self _______________
Feeding Habits: _______________

Document the following on all patients 1 year of age and under.

Head circumference _______________
Neck: Supple / Rigid Cry: Lusty / Weak
Anterior Fontanel (Full, Level, Depressed)

PEDIATRIC PATIENTS (0-12 YEARS) (Please circle)

1. History of breath holding spells?	YES	NO
2. History of Premature Birth?	YES	NO
a. Was Oxygen used?	YES	NO
b. Was a ventilator used to assist breathing?	YES	NO
3. History of jaundice?	YES	NO
4. Muscular problems?	YES	NO
5. Growth/developmental delays?	YES	NO
6. Respiratory difficulties?	YES	NO
7. Frequent colds?	YES	NO

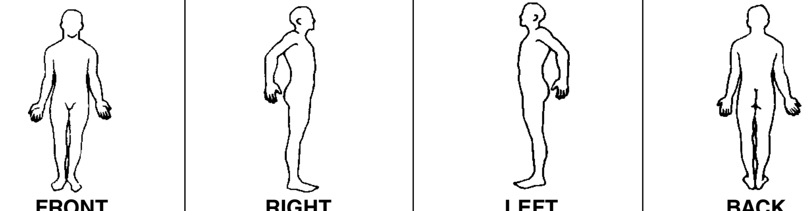
8. Birth weight _______________ Birth length _______________
9. Diaper Area: ( ) Red ( ) Blisters ( ) Skin Breaks

PATIENT LABEL

WOUND ASSESSMENT

NO WOUNDS AT THIS TIME ☐

MARK THE **location** OF ALL WOUNDS WITH A # ON BODY DIAGRAM. (Include pressure ulcers, chronic ulcers, post op wounds, skin tears, lacerations, etc.)



PRESSURE ULCER STAGE CODE
I. Skin intact with inflammation or reddening .
II. Superficial skin break with redness of surrounding area: including blisters. Includes intact, discolored heels.
III. Skin break with deep tissue involvement. May have necrotic or eschar tissue.
IV. Skin break with deep tissue, muscle and/ or bone involvement. May have necrotic or eschar tissue. May have tunneling / undermining.

DRAINAGE/ODOR
S = Serosanguinous M = Mild Odor
P = Purulent F = Foul Odor
Ø = No Drainage Ø = No Odor

WOUND NUMBER	#1	#2	#3	#4	#5	#6
LOCATION						
SIZE						
STAGE						
DRAINAGE/ODOR						

SPIRITUAL / CULTURAL NEEDS
(RN Only)

Religious / Beliefs Denomination _______________
1. Is your faith/spirituality an important part of your life? ( ) Yes ( ) No
2. Will being in the hospital interfere with any religious or cultural practices? (include possibility of blood transfusion) ( ) Yes ( ) No
Describe _______________
3. Do you have any specific requests to meet your Spritual/Cultural needs during this hospitalization? ( ) Yes ( ) No
Describe _______________

*** Generate Referrals As Appropriate**

PSYCHOSOCIAL NEEDS
Are there any special difficulties produced by this hospitalization? (Work, child care, family, etc.) ( ) Yes ( ) No
If yes, explain _______________

EDUCATIONAL NEEDS
( ) Current Illness ( ) Nutrition / Diet
( ) Treatment Plan ( ) Rehabilitative Techniques
( ) Medications ( ) Community Resources
( ) Pain Control/Management **(Brochure Provided)** ( ) Personal Hygiene / Grooming
( ) Medical Equipment ( ) Other

*** Generate Referrals As Appropriate**
***Document Education On Interdisciplinary Education Record**

ASSETS / BARRIERS TO PLAN OF CARE / EDUCATION

	Describe	No Barrier
1. Previous Experience / Knowledge Related To Reason For This Hospitalization		
2. Emotional / Relational Support System		
3. Describe family's plan for involvement in care during & after hospitalization.		
4. Hearing	Hearing Aid (R / L) ( ) Hearing Impaired ( )	
5. Vision	Corrected with: Glasses ( ) Contacts ( ) Impaired / Not Corrected ___ Blind ___	
6. Language		
7. Physical		
8. Cognition / Mental Status		
9. Cultural / Religious		
10. Other (i.e. financial)		