

UT-HARRIS COUNTY PSYCHIATRIC CENTER

INITIAL NURSING ASSESSMENT AND ADMISSION DATA (To be completed by any RN)

Page 6 of 12 (\*Indicates a trigger to the MPA)

ADMISSIONS DATA (To be completed by an RN/LVN) \_\_\_\_\_ LVN

Date: \_\_\_\_\_ Time of arrival on unit: \_\_\_\_\_ AM/PM Age: \_\_\_\_\_ Admitted by: \_\_\_\_\_ Status: \_\_\_\_\_

Accompanied by: \_\_\_\_\_ Data Source: \_\_\_\_\_ (specify)

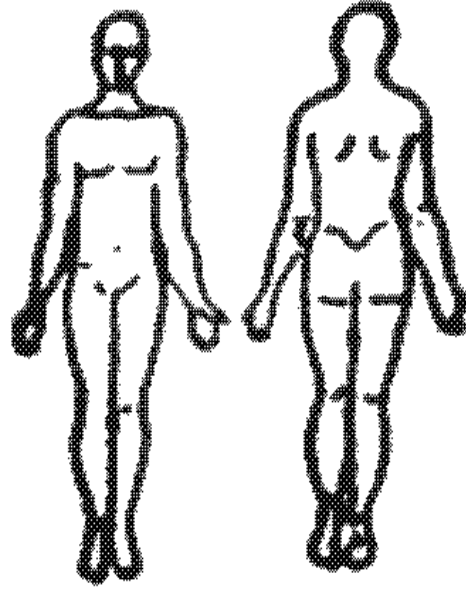
Admission Vital Signs: HT: \_\_\_\_\_ ft. \_\_\_\_\_ in. WT: \_\_\_\_\_ lbs. BP: \_\_\_\_\_ T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ Usual WT: \_\_\_\_\_ Actual Weight: \_\_\_\_\_

BODY/SAFETY SEARCH: Performed by \_\_\_\_\_ Name \_\_\_\_\_ LVN/RN, \_\_\_\_\_ Name \_\_\_\_\_ LVN/PT

Indicate Code to Show Location and describe below:

- C - Contusion
L - Lacerations
R - Rashes
S - Scars \*Parasite (scabies/lice)
D - Decubitus
T - Tattoo
B - Bruises
X - Body Piercing
P - Pain
O - Other \_\_\_\_\_ (specify)

Tinea Pedis: \_\_\_\_\_ Yes \_\_\_\_\_ No Describe: \_\_\_\_\_



Chief complaint (in patient's own words) \_\_\_\_\_

Source: \_\_\_\_\_ Patient \_\_\_\_\_ Family \_\_\_\_\_ Friend \_\_\_\_\_ Other (specify): \_\_\_\_\_

Current Medications (including vitamin/herbal supplements): \_\_\_\_\_

Disposition of medications: \_\_\_\_\_ None \_\_\_\_\_ Home \_\_\_\_\_ Pharmacy \_\_\_\_\_ Other (specify): \_\_\_\_\_

Have you taken any medications within the last 24 hours? If so, what? \_\_\_\_\_

Allergies: \_\_\_\_\_ NKDA \_\_\_\_\_ Other (specify): \_\_\_\_\_ Food (specify): \_\_\_\_\_

RN/LVN \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



<b>FUNCTIONAL SCREEN:</b> (To be completed by an RN)				
<b>Trigger to MPA for possible PT/OT referral if there is any new onset deficit(s).</b>				
<b>Walking:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision required <input type="checkbox"/> Assistance required <input type="checkbox"/> *Total assistance required	<b>Eating:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision required <input type="checkbox"/> Assistance required <input type="checkbox"/> *Total assistance required	<b>Dressing:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision required <input type="checkbox"/> Assistance required <input type="checkbox"/> *Total assistance required	<b>Bathing:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision required <input type="checkbox"/> Assistance required <input type="checkbox"/> Total assistance required	<b>Toileting:</b> <input type="checkbox"/> Independent <input type="checkbox"/> Supervision required <input type="checkbox"/> Assistance required <input type="checkbox"/> *Total assistance required
<b>Special Equipment:</b> <input type="checkbox"/> *Walker <input type="checkbox"/> *Wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Prosthesis <input type="checkbox"/> None <input type="checkbox"/> Hearing aids <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Dentures (partial-upper-lower)				
<b>FALL RISK ASSESSMENT</b> (To be completed by an RN)				
<u>Directions:</u> Score each area related to patient's current status by circling the appropriate value. Weights are in the right column and totals are reflected below the table. The form must be completed on Admission and during the course of hospitalization as needed.				
<b>HISTORY</b>	HISTORY OF PREVIOUS FALLS	2		
<b>PHYSICAL STATUS</b>	FATIGUE/WEAKNESS	2		
	DIZZINESS/BALANCE PROBLEMS	1		
	IMPAIRED MOBILITY	1		
	SENSORY IMPAIRMENT	1		
	SEIZURE DISORDER	1		
	ALTERATION IN ELIMINATION	1		
<b>MENTAL STATUS</b>	CONFUSED (ILLOGICAL THINKING)	2		
	IMPAIRED MEMORY/JUDGMENT	2		
	DISORIENTED TO PERSON/PLACE/TIME	2		
	LACK OF FAMILIARITY WITH IMMEDIATE SURROUNDINGS	1		
	INABILITY TO UNDERSTAND/FOLLOW INSTRUCTIONS	1		
<b>MEDICATION</b>	DRUGS THAT HAVE DIURETIC EFFECT	1		
	DRUGS THAT ALTER THOUGHT PROCESS AND/OR CREATE HYPOTENSIVE EFFECT (NARCOTICS, SEDATIVES, PSYCHOTROPICS, HYPNOTICS, TRANQUILIZERS, ANTI-HYPERTENSIVE)	1		
	DRUGS THAT INCREASE GI MOTILITY (LAXATIVES, ENEMAS, CATHARTICS)	1		
	MULTIPLE DRUGS FROM DIFFERENT DRUG CLASSIFICATIONS	1		
NOTE: (A score of <u>5 or above</u> indicates patient is at a potential risk for falls.)    TOTAL SCORE _____ <input type="checkbox"/> Initiate Fall Precautions (Trigger to MPA) <input type="checkbox"/> Assessed - No risk factors				

**REVIEW OF SYSTEMS (To be completed by an RN)**

**Respiratory:**  No hx of problems  
 Cough  Emphysema  SOB  
 Asthma  COPD  Dyspnea  
 Other (specify) \_\_\_\_\_  
 \_\_\_\_\_  
 Date of last TB test: \_\_\_\_\_ Result: \_\_\_\_\_  
 Treatment?  Yes  No If yes, what? \_\_\_\_\_  
 CXR?  Yes  No If yes, date? \_\_\_\_\_  
 Comment: \_\_\_\_\_  
 \_\_\_\_\_

**Skin:**  
 Intact  Pale  Dusky  
 Dry  Diaphoretic  Mottled  
 Cyanotic  Flushed  Other \_\_\_\_\_  
 Warm  Moist  
 Comment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Central Nervous System:**  No hx of problems  
 Dizziness  Sedation  Abnormal pupil size  
 Aphasia  Ataxia  Paralysis  
 Slurred speech  Tics (describe) \_\_\_\_\_  
 Seizure disorder  Other \_\_\_\_\_  
 Headache  
 Comment: \_\_\_\_\_  
 \_\_\_\_\_

**Genitourinary:**  No hx of problems  
 Pregnant  Urinary incontinence  Hematuria  
 Retention  Amenorrhea  Enuresis  
 Having menses  Venereal disease  Dysuria  
 Urgency  Other \_\_\_\_\_  
 Dysmenorrhea  
 Comment: \_\_\_\_\_  
 \_\_\_\_\_

**Gastrointestinal:**  No hx of problems  
 Vomiting  Nausea  Blood in stool  
 Diarrhea  Ulcer  Hepatitis  
 Constipation  Other \_\_\_\_\_  
 Comment: \_\_\_\_\_  
 \_\_\_\_\_

**Cardiovascular:**  No hx of problems  
 Angina  HTN  Peripheral edema  
 HX MI  Pacemaker  Chest pain  
 SOB  Heart murmur  
 Comment: \_\_\_\_\_  
 \_\_\_\_\_

**Other:**  N/A  
 Hypothyroid  Diabetes  HIV+  AIDS  
 Hyperthyroid  
 Hepatitis (specify) \_\_\_\_\_  
 Other (specify) \_\_\_\_\_  
 Other (specify) \_\_\_\_\_  
 Comment: \_\_\_\_\_  
 \_\_\_\_\_


**Musculoskeletal:**  No hx of problems  
 Cast  Joint swelling  
 Muscle spasms  Joint stiffness  
 Amputation  Fracture (describe) \_\_\_\_\_  
 Back pain  Other \_\_\_\_\_  
 Joint pain  
 Comment: \_\_\_\_\_  
 \_\_\_\_\_

**PAIN ASSESSMENT (To be completed by an RN)**

Do you have pain now?  Yes  No  
 If yes, proceed with the pain assessment below:

- Intensity Scales (See instructions on back):

**Wong-Baker FACES Pain Rating Scale\*\***



0 NO HURT      1 HURTS LITTLE BIT      2 HURTS LITTLE MORE      3 HURTS EVEN MORE      4 HURTS WHOLE LOT      5 HURTS WORST

Current pain score \_\_ (enter on graphic sheet) **Trigger to MPA, if pain rating is 2 or more**

What is the best your pain every gets? Score \_\_\_\_\_  
 What is the worst your pain every gets? Score \_\_\_\_\_  
 What makes your pain better? \_\_\_\_\_  
 What makes your pain worst? \_\_\_\_\_

What methods have you used to successfully control your pain? \_\_\_\_\_  
 What can we do to help you manage your pain? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Character  Sharp  Dull  Throbbing  Stabbing  Aching  Burning  Numb
- Frequency \_\_\_\_\_
- Location (specify area) \_\_\_\_\_
- Duration  Constant  Intermittent

\*\*From Wong, D.L., Hockenberry-Eaton, M., Wilson, D., Winkelstein, M.L., Ahmann, E., DiVito-Thomas, P.A.: Whaley and Wong's Nursing Care of Infants and Children, ed. 6, St. Louis, 1999, p. 2040. Copyrighted by Mosby, Inc. Reprinted by permission.

<b>PSYCHIATRIC ASSESSMENT (To be completed by an RN)</b>				
<b>LOC:</b> <input type="checkbox"/> ALERT <input type="checkbox"/> RESPONSIVE <input type="checkbox"/> DECREASED CONSCIOUS DESCRIBE: _____ _____	<b>ORIENTATION:</b> <input type="checkbox"/> PERSON <input type="checkbox"/> PLACE <input type="checkbox"/> TIME <input type="checkbox"/> SITUATION DESCRIBE: _____ _____	<b>MEMORY:</b> <input type="checkbox"/> INTACT <input type="checkbox"/> DIFFICULTY NOTED WITH SHORT-TERM <input type="checkbox"/> DIFFICULTY NOTED WITH LONG-TERM DESCRIBE: _____ _____		
<b>SPEECH:</b> <input type="checkbox"/> NORMAL RATE/VOLUME <input type="checkbox"/> PRESSURED <input type="checkbox"/> HESITANT <input type="checkbox"/> LOUD <input type="checkbox"/> SLURRED <input type="checkbox"/> MUTE <input type="checkbox"/> OTHER DESCRIBE: _____ _____	<b>PSYCHOMOTOR:</b> <input type="checkbox"/> WITHIN NORMAL LIMITS <input type="checkbox"/> AGITATION <input type="checkbox"/> RESTLESSNESS <input type="checkbox"/> RETARDATION <input type="checkbox"/> POOR POSTURE DESCRIBE: _____ _____	<b>MOOD:</b> <input type="checkbox"/> APPROPRIATE <input type="checkbox"/> DYSPHORIC <input type="checkbox"/> DEPRESSED <input type="checkbox"/> EUTHYMIC <input type="checkbox"/> ELATED DESCRIBE: _____ _____		
<b>BEHAVIOR(S):</b> <input type="checkbox"/> COOPERATIVE <input type="checkbox"/> THREATENING <input type="checkbox"/> UNCOOPERATIVE <input type="checkbox"/> LABILE <input type="checkbox"/> WITHDRAWN <input type="checkbox"/> ANGRY <input type="checkbox"/> DEMANDING <input type="checkbox"/> HOPELESS DESCRIBE: _____ _____	<b>THOUGHT CONTENT:</b> <input type="checkbox"/> APPROPRIATE TO SITUATION <input type="checkbox"/> HALLUCINATIONS <input type="checkbox"/> DELUSIONS <input type="checkbox"/> TACTILE <input type="checkbox"/> PERSECUTORY <input type="checkbox"/> OLFACTORY <input type="checkbox"/> GRANDIOSE <input type="checkbox"/> AUDITORY <input type="checkbox"/> _____ <input type="checkbox"/> VISUAL                                      (SPECIFY) DESCRIBE: _____ _____	<b>THOUGHT PROCESS:</b> <input type="checkbox"/> GOALS DIRECTED <input type="checkbox"/> TANGENTIAL <input type="checkbox"/> APPROPRIATE <input type="checkbox"/> CIRCUMSTANTIAL <input type="checkbox"/> DISORGANIZED <input type="checkbox"/> LOOSE DESCRIBE: _____ _____		
<b>APPEARANCE:</b> <input type="checkbox"/> WELL GROOMED <input type="checkbox"/> POOR HYGIENE <input type="checkbox"/> NEAT/CLEAN <input type="checkbox"/> DISHEVELED <input type="checkbox"/> APPROPRIATE FOR CLIMATE DESCRIBE: _____ _____	<b>SELF-HARM ASSESSMENT:</b> PAST OR CURRENT HX OF SUICIDE/SELF-MUTILATION: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE _____ FAMILY HX OF SUICIDE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE _____ CONTRACTS FOR SAFETY: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFUSES AT THIS TIME DETERRENDS: _____ TRIGGERS: _____			
<b>AGGRESSION TO OTHERS/PROPERTY:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE: _____ _____ CURRENT THOUGHTS OF HARMING OTHERS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE: _____ _____ LEGAL/SCHOOL PROBLEMS DUE TO AGGRESSION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE: _____ _____ PAST OR CURRENT HOMICIDAL IDEATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE: _____ <input type="checkbox"/> RAGE <input type="checkbox"/> OTHER _____ _____ _____			<b>SECLUSION/RESTRAINT:</b> <b>TRIGGERS:</b> <input type="checkbox"/> HEARING VOICES <input type="checkbox"/> FEELING AFRAID <input type="checkbox"/> FEELING ANGRY <input type="checkbox"/> TOO MUCH NOISE <input type="checkbox"/> OTHER (SPECIFY) _____ <input type="checkbox"/> OTHER (SPECIFY) _____ <b>PREVENTION STRATEGIES:</b> <input type="checkbox"/> 1:1 TIME <input type="checkbox"/> CHANGE OF ENVIRONMENT <input type="checkbox"/> READING <input type="checkbox"/> ADMINISTRATION OF MEDS <input type="checkbox"/> REDUCE STIMULI <input type="checkbox"/> LISTEN TO MUSIC <input type="checkbox"/> RELAXATION TECHNIQUES (SPECIFY) _____ <b>PREEXISTING CONDITION(S):</b> <input type="checkbox"/> NONE <input type="checkbox"/> HX OF SEXUAL/PHYSICAL ABUSE <input type="checkbox"/> PHYSICAL DISABILITY/LIMITATION <input type="checkbox"/> MEDICAL CONDITION (SPECIFY) _____ <b>PRIOR HX OF SECLUSION/RESTRAINT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>FAMILY NOTIFICATION:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SEE AUTHORIZATION FORM FOR CONTACT INFORMATION	

**NUTRITIONAL SCREEN: (To be completed by RN)**

(See page 6 for Usual Wt, Ht, and Wt)

Diet (prior to admission): \_\_\_\_\_  
 Appetite (prior to admission):  Good  Fair  Poor

Points Rating	Description	Total Points
<b>3 Pts Each</b>	<input type="checkbox"/> Diabetes (new dx) <input type="checkbox"/> Liver <input type="checkbox"/> Pregnancy <input type="checkbox"/> Malnutrition (BMI <18.5) <input type="checkbox"/> Renal disease <input type="checkbox"/> Underweight or short stature in children (<5 <sup>th</sup> percentile for ht) <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hepatitis	_____
<b>2 Pts Each</b>	<input type="checkbox"/> HTN <input type="checkbox"/> Cardiac (CHF, CAD) <input type="checkbox"/> COPD <input type="checkbox"/> GI disorder <input type="checkbox"/> Diabetes (uncontrolled) <input type="checkbox"/> Symptoms of eating disorder (laxative abuse, induced vomiting, diuretic use)	_____
<b>1 Pt Each</b>	<input type="checkbox"/> Chewing and swallowing problems <input type="checkbox"/> Vomiting >48 hrs <input type="checkbox"/> Diarrhea >48 hrs <input type="checkbox"/> Chronic constipation <input type="checkbox"/> Low albumin (<2.8) <input type="checkbox"/> Food allergies <input type="checkbox"/> BMI > 40 and patient desires a consult	_____
<b>Grand Total</b>		_____

**Enter a Dietary/Nutritional Consult (a Physician Order is not required) for all patients with a Grand Total score of at least 1.**

Patient desires consult  Patient refuses consult

**Risk Levels:**  No Risk  Low (1-4)  Moderate (5-7)  High (>7), **Guidelines for Nutritional Assessment/Reassessment:**

**PATIENT/FAMILY EDUCATION (To be completed by RN) Education must be conducted on bold topics**

TOPIC	METH	EVAL	F/UP	COMMENTS	TOPIC	METH	EVAL	F/UP	COMMENTS
<b>PAIN MGMT RIGHTS/ PATIENT GUIDE</b>					MEDICATION				
<b>ORIENTATION: PATIENT GUIDE</b>					FALL PREVENTION				
<b>ORIENTATION: UNIT ORIENTATION</b>					SUICIDE PREVENTION				
<b>PERSONAL HYGIENE/GROOMING</b>									
<b>PATIENT SAFETY/SPEAK UP</b>									
<b>INITIAL PLAN OF CARE</b>									
<b>SECLUSION/ RESTRAINT PHILOSOPHY</b>									

METHODS	EVALUATION	FOLLOW-UP
E. EXPLANATION	1. IDENTIFIES KEY POINTS	1. RETEACH MATERIAL
D. DEMONSTRATION	2. VERBALIZES UNDERSTANDING	2. REINFORCE CONTENT
R. ROLE PLAY	3. RETURNS DEMONSTRATION	3. REPEAT DEMONSTRATION
AV. AUDIOVISUAL	4. PERFORMS SKILLS INDEPENDENTLY	4. ASSIST WITH SKILLS
H. HANDOUT	5. APPLIES KNOWLEDGE	5. NONE REQUIRED
I. INDIVIDUAL	6. NO EVIDENCE OF LEARNING	6. SEE PROGRESS NOTES
G. GROUP	7. PATIENT REFUSAL	OTHER (specify)
F. FAMILY	8. UNABLE TO EVALUATE (Specify)	
OTHER (specify)	OTHER (specify)	

<b>INITIAL NURSING CARE PLAN (To be completed by an RN)</b>	
<b>Nursing Care Problem as evidenced by (RN)</b>	<b>Planned Intervention</b>
1) as evidenced by	
2) as evidenced by	
3) as evidenced by	
4) as evidenced by	
5) as evidenced by	

MY SIGNATURE INDICATES THAT I HAVE COMPLETED THE INITIAL NURSING ASSESSMENT AND HAVE REVIEWED/AGREE WITH THE ADMISSION DATA CAPTURED BY THE LVN (IF APPLICABLE)

RN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_