

NOTE TO NURSING STAFF:

The information on this form is to be entered into the "Health History Summary" in ProvClinicals. Nursing still needs to document in the "Chart Admit Data Episodic" tab with the rest of the admit assessment. This form is to be shredded after the data is entered into ProvClinicals **EXCEPT** when used as a downtime form.



Data entered into ProvClinicals: NO

Name: _____ Date: ____/____/____

Primary Language: English Other: _____

Interpreter: Y N Name: _____

CONTACTS:

Primary Contact Name: _____ Relationship: _____ Number: _____

Secondary Contact Name: _____ Relationship: _____ Number: _____

Advanced Directives: Y N Info given: Y N Pt less than 18 ____ If yes, where is a copy? _____

Do you have a POLST form? Y N Are you an organ donor? Y N Unknown

IMMUNIZATIONS:

- Tetanus / Diptheria (how many years?): <5 yrs <10 yrs >10 yrs Never Unknown Date: ____/____/____
- Pneumonia (within last five years?): <5 yrs >5 yrs Never Unknown Date: ____/____/____
- Flu Shot: Current season Prior season Never Unknown Date: ____/____/____
- Others (check if yes): Hepatitis A Hepatitis B Chicken Pox
- Childhood Immunizations: Y N Unknown Comments: _____

Allergies / with associated reactions (if known): _____

SUBSTANCE USE:

TYPE	Y / N	HOW MUCH	HOW OFTEN	LAST DATE USED	QUIT DATE	TYPE
Smoke (Tobacco)*						
* Smoking Cessation advice or council given: <input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> N/A patient condition						
Alcohol						
Marijuana						
Cocaine						
Meth Amphetamines						
Heroin						
IV Substance Use						
Other Substance(s)						



Patient Identification:

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PAIN: not applicable

When did you start having pain? Days: _____ Weeks: _____ Months: _____

Pain location: _____

Pain rating (0-10): _____ Additional Comments: _____

Quality / Character: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Constant <input type="checkbox"/> Cramping <input type="checkbox"/> Crushing <input type="checkbox"/> Deep <input type="checkbox"/> Dull <input type="checkbox"/> Gnawing <input type="checkbox"/> Heavy <input type="checkbox"/> Hurting <input type="checkbox"/> Numbness <input type="checkbox"/> Indigestion <input type="checkbox"/> Incisional <input type="checkbox"/> Phantom	<input type="checkbox"/> Positional <input type="checkbox"/> Pressure <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Sore <input type="checkbox"/> Spasms <input type="checkbox"/> Squeezing <input type="checkbox"/> Stabbing <input type="checkbox"/> Tingling <input type="checkbox"/> Throbbing <input type="checkbox"/> Tightness <input type="checkbox"/> Touch sensitive <input type="checkbox"/> Uncomfortable <input type="checkbox"/> unable to describe	Aggravated By: <input type="checkbox"/> Activity <input type="checkbox"/> ADL's <input type="checkbox"/> Awakening in am <input type="checkbox"/> Cough <input type="checkbox"/> Deep breath <input type="checkbox"/> Eating <input type="checkbox"/> Exercise <input type="checkbox"/> Lying down <input type="checkbox"/> Movement <input type="checkbox"/> Palpation <input type="checkbox"/> Resting <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Swallowing <input type="checkbox"/> Walking	Alleviating Factors: <input type="checkbox"/> Cold <input type="checkbox"/> Elevation <input type="checkbox"/> Heat <input type="checkbox"/> Movement <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying down <input type="checkbox"/> Relaxation <input type="checkbox"/> Rest <input type="checkbox"/> Medications <input type="checkbox"/> Eating <input type="checkbox"/> Exercise <input type="checkbox"/> Massage <input type="checkbox"/> Repositioning <input type="checkbox"/> Sleep <input type="checkbox"/> Distraction <input type="checkbox"/> TENS unit <input type="checkbox"/> Vomiting	Effects of Pain: <input type="checkbox"/> Decreased endurance <input type="checkbox"/> Decreased activity <input type="checkbox"/> Unable to sleep <input type="checkbox"/> Aggressive behavior <input type="checkbox"/> Decreased motivation <input type="checkbox"/> Crying <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Emotional fretful <input type="checkbox"/> Emotional tearful	Pain Goal: <input type="checkbox"/> Pain free <input type="checkbox"/> Dec. pain level <input type="checkbox"/> Other <input type="checkbox"/> Perform activity <input type="checkbox"/> Sleep comfortably <input type="checkbox"/> Comfort at rest <input type="checkbox"/> Comfort with movement Pain Goal #: _____
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MEDICAL HISTORY:

Cancer: <input type="checkbox"/> No history <input type="checkbox"/> Bladder <input type="checkbox"/> Blood <input type="checkbox"/> Bone <input type="checkbox"/> Brain <input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Colon <input type="checkbox"/> Esophageal <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Lymph <input type="checkbox"/> Ovarian <input type="checkbox"/> Pancreatic <input type="checkbox"/> Prostate <input type="checkbox"/> Rectal <input type="checkbox"/> Skin <input type="checkbox"/> Stomach <input type="checkbox"/> Thyroid <input type="checkbox"/> Uterine <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Surgical intervention <input type="checkbox"/> Other - note Comments: _____ _____ _____	Neurological: <input type="checkbox"/> No history <input type="checkbox"/> ALS <input type="checkbox"/> Alzheimers <input type="checkbox"/> Guillain Barre <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Head injury <input type="checkbox"/> Seizures <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Confusion <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting <input type="checkbox"/> Numb areas <input type="checkbox"/> Paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Other - note Comments: _____ _____ _____	Eyes / Ears / Nose / Throat: <input type="checkbox"/> No history <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Impaired vision <input type="checkbox"/> Blind <input type="checkbox"/> Lens implants <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Artificial eye <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Hearing aids <input type="checkbox"/> Loose teeth <input type="checkbox"/> Dentures <input type="checkbox"/> Dental caps <input type="checkbox"/> Dental bridges <input type="checkbox"/> Electrolarynx <input type="checkbox"/> Other - note Comments: _____ _____ _____	Musculoskeletal: <input type="checkbox"/> No history <input type="checkbox"/> Fractures other <input type="checkbox"/> Arthritis <input type="checkbox"/> Broken back <input type="checkbox"/> Broken facial bones <input type="checkbox"/> Broken neck <input type="checkbox"/> Broken pelvis <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Degenerative disease <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> TMJ <input type="checkbox"/> Limited ROM <input type="checkbox"/> Back pain <input type="checkbox"/> Other- note Comments: _____ _____ _____	Cardiovascular: <input type="checkbox"/> No history <input type="checkbox"/> Blood Clots <input type="checkbox"/> Congenital defect <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Hear Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Mitral Valve prolapse <input type="checkbox"/> PVD <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator <input type="checkbox"/> Stent <input type="checkbox"/> Other- see note Comments: _____ _____ _____	Respiratory: <input type="checkbox"/> No history <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Chronic Cough <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Heavy Snoring <input type="checkbox"/> Short of Breath <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Upper resp infect <input type="checkbox"/> Other - note Comments: _____ _____ _____
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Patient Identification:

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MEDICAL HISTORY (cont.):

<p>Gastrointestinal:</p> <input type="checkbox"/> No history <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Gall Bladder disease <input type="checkbox"/> GERD <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Hyperemesis <input type="checkbox"/> Inflammatory bowel <input type="checkbox"/> Intestinal bleeding <input type="checkbox"/> Irritable bowel <input type="checkbox"/> Ostomy <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Ulcers <input type="checkbox"/> Other-note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Renal / Urinary:</p> <input type="checkbox"/> No history <input type="checkbox"/> Dialysis <input type="checkbox"/> Freq urinary infections <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney disease <input type="checkbox"/> Urostomy <input type="checkbox"/> Other- note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Skin:</p> <input type="checkbox"/> No history <input type="checkbox"/> Edema <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Bruises easily <input type="checkbox"/> Skin infections <input type="checkbox"/> Ulcer / wound <input type="checkbox"/> Other- note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Reproductive:</p> <input type="checkbox"/> No history <input type="checkbox"/> Births <input type="checkbox"/> GYN problems <input type="checkbox"/> Prostate problems <input type="checkbox"/> STD's <input type="checkbox"/> Other-note <p>Birth Control Method:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Reproductive Note:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Additional History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Behavioral Health:</p> <input type="checkbox"/> No history <input type="checkbox"/> ADHD <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Eating disorder <input type="checkbox"/> OCD <input type="checkbox"/> Panic attacks <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Other-note: <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Anemia / Bleeding:</p> <input type="checkbox"/> No history <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Other-note <p>Endocrine:</p> <input type="checkbox"/> No History <input type="checkbox"/> Immune disorders <input type="checkbox"/> Diabetes - Insulin dep <input type="checkbox"/> Diabetes - Oral agent <input type="checkbox"/> Diabetes- Diet controlled <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Other-note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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SURGICAL HISTORY

<p>Anesthesia Hx Patient:</p> <input type="checkbox"/> No history <input type="checkbox"/> High fever <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Other - note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Anesthesia Hx (Blood Relative):</p> <input type="checkbox"/> No history <input type="checkbox"/> High fever <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Other- note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Blood Transfusion:</p> <input type="checkbox"/> No objection <input type="checkbox"/> Religious objection <input type="checkbox"/> Personal objection <input type="checkbox"/> Previous transfusion <input type="checkbox"/> Transfusion reaction <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Cardiovascular Procedures:</p> <input type="checkbox"/> No history <input type="checkbox"/> AAA Repair <input type="checkbox"/> Angiogram <input type="checkbox"/> Arch / Aortagram <input type="checkbox"/> CABG <input type="checkbox"/> Carotid Endarterectomy - L <input type="checkbox"/> Carotid Endarterectomy - R <input type="checkbox"/> Defibrillator <input type="checkbox"/> Fem-Fem Bypass - L <input type="checkbox"/> Fem-Fem Bypass - R <input type="checkbox"/> Fem-Pop Bypass - L <input type="checkbox"/> Fem-Pop Bypass - R <input type="checkbox"/> Heart Cath <input type="checkbox"/> Implanted venous access <input type="checkbox"/> Pacemaker insertion <input type="checkbox"/> PTBA <input type="checkbox"/> Valve Replacement <input type="checkbox"/> Varicose veins stripping <input type="checkbox"/> Other - note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Eyes / Ears / Nose / Throat Procedures:</p> <input type="checkbox"/> No history <input type="checkbox"/> Adenoids <input type="checkbox"/> Cataract Removal - L <input type="checkbox"/> Cataract Removal - R <input type="checkbox"/> Cleft Palate Repair <input type="checkbox"/> Myringotomy / Ear Tubes <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Sinus Surgery <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Other- note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Gastrointestinal Procedures:</p> <input type="checkbox"/> No history <input type="checkbox"/> Appendix <input type="checkbox"/> Bowel Resection <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Colonoscopy <input type="checkbox"/> EGD <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Laparoscopic Gastric Banding <input type="checkbox"/> Lap Band Procedure <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Inguinal Hernia Repair - L <input type="checkbox"/> Inguinal Hernia Repair - R <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Umbilicus Hernia Rep. <input type="checkbox"/> Incisional Hernia Rep. <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Other- note <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Patient Identification:

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SURGICAL HISTORY (cont.):

Gyn Procedures:

- No History
- Breast Bx - L
- Breast Bx - R
- C-section
- D and C
- Hysterectomy
- Mastectomy - L
- Mastectomy - R
- Salpingectomy
- Oophorectomy
- Total Hysterectomy
- Tubal Ligation
- Other-note

Comments:

Ortho Procedures:

- No History
- Ankle ORIF - L
- Ankle ORIF - R
- Back Surgery
- Bunionectomy
- Carpal Tunnel Release B
- Carpal Tunnel - L
- Carpal Tunnel - R
- Exc. Ganglion Cyst
- Foot Surgery - L
- Foot Surgery - R
- Hand Surgery - L
- Hand Surgery - R
- Hip ORIF - L
- Hip ORIF - R
- Hip Replacement - L
- Hip Replacement - R

Comments:

Ortho (continued):

- Knee ACL - L
- Knee ACL - R
- Knee Arthroscopic - L
- Knee Arthroscopic - R
- Knee Replacement - L
- Knee Replacement - R
- Knee Surgery - L
- Knee Surgery - R
- Rotator Cuff - L
- Rotator Cuff - R
- Shoulder Arthroscopic - L
- Shoulder Arthroscopic - R
- Shoulder Arthrot - L
- Shoulder Arthrot - R
- Other- note

Comments:

Urogenital Procedures:

- No History
- Bladder surgery
- Circumcision
- Cystoscopy
- Orchiectomy - Bilateral
- Orchiectomy - L
- Orchiectomy - R
- Hypospadias Repair
- Prostatectomy
- TURP
- Urostomy
- Vasectomy
- Other-note

Comments:

Additional History: _____

Previous Surgeries / Hospitalizations (approximate dates): _____

INFECTION CONTROL:

Exposure to HIV:

- Yes No
- Less than one year ago
- More than one year ago

Comments:

Exposure to MRSA

- Yes
- No
- Less than one year ago
- More than one year ago

Comments:

Exposure to Hep B

- Yes No
- Less than one year ago
- More than one year ago

Comments:

Exposure to other:

- Yes – annotate below
- No
- Less than one year ago
- More than one year ago

Comments:

Exposure to Hep C

- Yes No
- Less than one year ago
- More than one year ago

Comments:

Recent Exposure to:

- Chicken Pox
- Influenza
- Measles
- Meningitis
- Pertussis

Comments:

Exposure to VRE

- Yes No
- Less than one year ago
- More than one year ago

Comments:

TB Risk:

- Exposed To
- Night Sweats
- Productive Cough
- Recent unexplained fever
- Coughing blood
- Weight loss / loss of appetite
- Foreign travel
- Foreign residence
- Positive TB Test

Comments:



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BLOOD SUGAR MANAGEMENT:			
<p>For patients with Diabetes or Glucose Intolerance:</p> <input type="checkbox"/> Not Applicable	<p>Reaction Symptoms:</p> <p>Hypoglycemic Symptoms:</p> <input type="checkbox"/> Anxiety / nervous <input type="checkbox"/> Confusion <input type="checkbox"/> Dizzy <input type="checkbox"/> Fatigue <input type="checkbox"/> Fast heart beat <input type="checkbox"/> Headache <input type="checkbox"/> Hunger <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Nausea <input type="checkbox"/> None <input type="checkbox"/> Shaky <input type="checkbox"/> Sweaty <input type="checkbox"/> Vision change <input type="checkbox"/> Other-note <p>Comments:</p>	<p>Hyperglycemic Symptoms:</p> <input type="checkbox"/> Anxiety / nervous <input type="checkbox"/> Confusion <input type="checkbox"/> Dizzy <input type="checkbox"/> Fatigue <input type="checkbox"/> Fast heart beat <input type="checkbox"/> Headache <input type="checkbox"/> Hunger <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Nausea <input type="checkbox"/> None <input type="checkbox"/> Shaky <input type="checkbox"/> Sweaty <input type="checkbox"/> Vision change <input type="checkbox"/> Other-note <p>Comments:</p>	<p>Testing:</p> <p>Glucometer: _____</p> <hr/> <p>Frequency of testing:</p> <input type="checkbox"/> AC - HS <input type="checkbox"/> Twice Daily <input type="checkbox"/> Fasting - PC <input type="checkbox"/> Every day <input type="checkbox"/> Every week <input type="checkbox"/> Rarely <input type="checkbox"/> 3 times per week <p>Tested by:</p> <input type="checkbox"/> Caregiver <input type="checkbox"/> Family <input type="checkbox"/> Self <input type="checkbox"/> With spouse / Sig. other <input type="checkbox"/> Other-see note <p>Comments:</p>
<p>Home Routine:</p> <p>Home Blood Sugar Range: _____</p> <p>Diet Prescription: _____</p> <p>Snack & Times: _____</p>			

NUTRITIONAL SCREEN:			
<p>Nutritional History:</p> <input type="checkbox"/> No history <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Intentional weight gain <input type="checkbox"/> Intentional weight loss <input type="checkbox"/> Unintentional weight gain <input type="checkbox"/> Unintentional weight loss <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Pain related decreased appetite <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Eating disorder <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Special Diet <input type="checkbox"/> Difficulty feeding self <input type="checkbox"/> Food intolerance <input type="checkbox"/> Food allergies <input type="checkbox"/> Other-note	<p>Nutritional History (continued):</p> <p>Comments:</p>	<p>Weight gain / loss last 3 months: _____</p> <p>Tube Feedings: _____</p>	<p>Nutritional Supplement(s) : _____</p> <p>Dietician Consult ORDERED:</p> <input type="checkbox"/> Yes <input type="checkbox"/> Denies

FUNCTIONAL SCREEN:			
ADL's: <input type="checkbox"/> Independent <input type="checkbox"/> Assist w/hygiene <input type="checkbox"/> Assist w/bathing <input type="checkbox"/> Assist w/ toileting <input type="checkbox"/> Assist w/incontinence <input type="checkbox"/> Assist w/ dressing <input type="checkbox"/> Assist w/ cooking <input type="checkbox"/> Bath bench <input type="checkbox"/> Grab bars <input type="checkbox"/> Raised toilet seat <input type="checkbox"/> Commode <input type="checkbox"/> Incontinence pads <input type="checkbox"/> Incontinence briefs <input type="checkbox"/> Unable to assess <input type="checkbox"/> Other-note Comments: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	Mobility: <input type="checkbox"/> Independent <input type="checkbox"/> Fall <input type="checkbox"/> Walks w/assist <input type="checkbox"/> Walks w/cane <input type="checkbox"/> Walks w/walker <input type="checkbox"/> Walks w/crutches <input type="checkbox"/> WC independent <input type="checkbox"/> WC w/assist <input type="checkbox"/> Power WC <input type="checkbox"/> Transfers w/assist <input type="checkbox"/> Toilet Transfer w/assist <input type="checkbox"/> Stairs w/ assist <input type="checkbox"/> Stairs unable <input type="checkbox"/> Bed bound <input type="checkbox"/> Hospital bed <input type="checkbox"/> Mechanical lift <input type="checkbox"/> Unable to assess <input type="checkbox"/> Other-note Comments: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	Cognitive: <input type="checkbox"/> Independent <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Difficulty writing <input type="checkbox"/> Difficulty reading <input type="checkbox"/> Memory difficulty <input type="checkbox"/> TTY / TTD <input type="checkbox"/> Communication board <input type="checkbox"/> Unable to assess <input type="checkbox"/> Other-note Comments: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	Med & Tx Management: <input type="checkbox"/> Independent <input type="checkbox"/> Dependent <input type="checkbox"/> Assist with pillbox <input type="checkbox"/> Assist with syringes <input type="checkbox"/> Assist wound care <input type="checkbox"/> Assist ostomy care <input type="checkbox"/> Assist home CAPD <input type="checkbox"/> Assist Tube Drain Care <input type="checkbox"/> Assist Tube Feeding <input type="checkbox"/> Assist with IV care <input type="checkbox"/> Assist with trach care <input type="checkbox"/> Assist with resp tx <input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> Oxygen <input type="checkbox"/> Nebulizer <input type="checkbox"/> Unable to assess <input type="checkbox"/> Other-note Comments: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
SUPPORT:			
Cultural Traditions: <input type="checkbox"/> No <input type="checkbox"/> Yes (describe): <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	Personal concerns: <input type="checkbox"/> None <input type="checkbox"/> Cares for others <input type="checkbox"/> Overly fearful <input type="checkbox"/> Overly anxious <input type="checkbox"/> Recent loss <input type="checkbox"/> Inadequate Support Structure <input type="checkbox"/> No local support <input type="checkbox"/> Other - note: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	Support comments: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	Emergency services: <input type="checkbox"/> Able to contact <input type="checkbox"/> Unable to contact <input type="checkbox"/> Not available <input type="checkbox"/> Other - note: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

ADULT PERSONAL SAFETY SCREEN: (personal safety questions are to be asked by the nurse):			



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