McLAREN FLINT
FLINT, MICHIGAN
Behavioral Medicine
NURSES ASSESSMENT FORM

1. IDENTIFYING INFORMATION

NAME PATIENT PREFERS:

(If applicable) LEGAL GUARDIAN NAME AND PHONE NUMBER:

PHYSICAL ASSESSMENT COMPLETED BY:

TYPE OF ADMISSION: VOLUNTARY INVOLUNTARY

V/S TIME: BP: PULSE: TEMP: RR:

HEIGHT: WEIGHT: **ALLERGIES:**

PATIENT'S LEVEL OF EDUCATION:

2. DESCRIBE CHIEF COMPLAINT/REASON FOR SEEKING TREATMENT:

3. RECENT EXPOSURE TO INFECTIOUS OR CONTAGIOUS DISEASE? YES NO (DESCRIBE)

4. HISTORY OF SERIOUS ILLNESS OR INJURY

5. DOES PATIENT HAVE HISTORY OF: (circle)

SEIZURES	ULCERS	STDs
HYPERTENSION	DIABETES	OTHER:
STROKE	HEART DISEASE	
LIVER DISEASE	CANCER	
KIDNEY DISEASE	HIV	

6. DOES PATIENT CURRENTLY HAVE PROBLEMS WITH:

HEARING	BOWEL DISEASE OR PROBLEMS	AMBULATION - FREQUENT FALLS
EYESIGHT	ULCERS	SKIN RASHES OR ABRASIONS
CANCER	HEART DISEASE	OTHER:
DIABETES	NEUROMUSCULAR DISORDERS	
RESPIRATORY PROBLEMS		
PROBLEMS WITH URINATION		

SKIN FINDINGS: ☐ No Problem

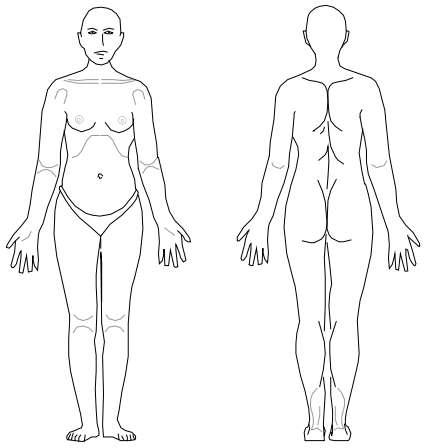
Skin disorders: ☐ Psoriasis ☐ Excema ☐ Rash Describe: _____

Itching? ☐ Yes ☐ No Describe: _____

Skin Turgor: ☐ Dry ☐ Elastic ☐ Cracked ☐ Other Describe: _____

_____

Number and explain any bruises, abrasions, scars, tatoos, etc.



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7. DOES PATIENT USE ANY AIDES OR PROSTHESIS? YES NO (DESCRIBE)

8. LAST MENSTRUAL PERIOD: **ABNORMAL VAGINAL BLEEDING/DISCHARGE** YES NO (DESCRIBE)

9. DOES PATIENT HAVE ANY CONCERNS RE: SEXUALITY YES NO (DESCRIBE)

10. DOES PATIENT HAVE EDUCATIONAL NEEDS RE: HIGH RISK SEXUAL BEHAVIORS OR BIRTH CONTROL METHODS? YES NO (DESCRIBE)

11. DOES PATIENT REPORT EXPERIENCING ANY FORM OF ABUSE (PHYSICAL/SEXUAL/ EMOTIONAL) BY ANYONE? YES NO (DESCRIBE)

12. NUTRITION SCREEN IN THE LAST 3 MONTHS

Have you had any problems chewing or swallowing that prevents you from eating properly?	YES	NO
Have you lost or gained more than 10 pounds?	YES	NO
Do you have any food allergies, intolerances, or religious/cultural food practices that you follow? If yes, please list Likes_____ Dislikes_____	YES	NO
Do you take herbal supplements? Physician alerted? _____	YES	NO
Unless it is part of your medical nutritional therapy, supplements, snacks will be by physician order only.	YES	NO
Have you had a decrease in your appetite and/or the amount of food you eat?	YES	NO
Have you had dental problems?	YES	NO

13. Have you ever had issues with eating (for example, bingeing on food, refusing to eat, or intentionally causing yourself to vomit?) If yes, ask - Have you ever been diagnosed with an eating disorder?" YES OR NO (DESCRIBE)

If yes response to any of the questions above, forward nutrition alert to nutritional services (tube down).

14. Does patient experience any type of chronic pain? YES NO (DESCRIBE)

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15. Is patient experiencing any pain or discomfort now? YES NO (IF YES, COMPLETE ASSESSMENT)

Location	Duration	Character	Intensity
Precipitating factors:			
Method of treatment/relief methods used:			

16. *PAIN ASSESSMENT SCALE*

NONE	MILD	MODERATE	SEVERE	VERY SEVERE	WORST EVER
NONE	ANNOYING	UNCOMFORTABLE	DISTRESSING	HORRIBLE	AGONIZING
0	1 – 2	3 – 4	5 - 6	7 – 8	9 - 10

Intervention:

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McLAREN FLINT

FLINT, MICHIGAN

Behavioral Medicine

NURSES ASSESSMENT FORM

17. FALL RISK ADMISSION ASSESSMENT TOOL

INSTRUCTION: Upon admission assess the patient status in the nine clinical condition parameters listed below (A-I). Assign the corresponding score which best describes the patient in the appropriate column. Add the column of numbers to obtain the total score. Refer to the Fall Risk policy for interventions to be initiated for each fall risk level.

SCORING:

0 - 8 = Low Risk (Green Light)

9 - 12 = Moderate Risk (Yellow Light)

> 12 = High Risk (Red Light)

DATE:	_____ / _____ / _____
TIME:	_____

PARAMETER	SCORE	PATIENT STATUS / CONDITION	
A. History of Falls (past 3 months)	0	NO FALLS in past 3 months	
	2	1-2 falls in past 3 months	
	4	3 or more falls in past 3 months	
B. Predisposing Diseases Respond based on the following predisposing conditions: Hypotension, Vertigo, CVA, Parkinson's disease, Loss of limb(s), Seizures, Arthritis, Osteoporosis, Fractures.	0	None present	
	2	1-2 present	
	4	3 or more present	
C. Medications Respond based on the following types of medications: Anesthestics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropic, Sedatives/Hypnotics.	0	None of these medications taken currently or within the last 7 days	
	2	Takes 1-2 of these medications currently and/or within the last 7 days	
	4	Takes 3-4 of theses medications currently and/or within the last 7 days	
	1	Score 1 additional point if the patient has had a change in type or dosage of a medication in the past 5 days	
D. Systolic Blood Pressure Only if recent syncopal episode	0	No drop noted between lying and sitting B/P	
	2	Drop less than 20mm Hg between lying and standing B/P	
	4	Drop MORE THAN 20mm Hg between lying and standing B/P	
E. Level Of Consciousness/ Mental Status	0	Alert/Oriented x3 or Comatose	
	2	Disoriented x3 at all times	
	4	Intermittent confusion	
F. Vision Status	0	Adequate (with or without glasses)	
	2	Poor (with or without glasses)	
	4	Legally blind	

- SEE REVERSE -

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DATE:	_____ / _____ / _____
TIME:	_____

PARAMETER	SCORE	PATIENT STATUS / CONDITION	
G. Ambulation / Eliination Therapy	0	Ambulatory/Continent	
	2	Chair bound - Requires restraints and/or assistance with elimination	
	4	Ambulatory/Incontinent	
H. Gait / Balance To assess the patient's gait/balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway and make a turn.	0	Gait/Balance normal	
	1	Balance problem while standing	
	1	Balance problem while walking	
	1	Decreased muscular coordination	
	1	Change in gait pattern when walking through doorway	
	1	Jerking or unstable when making turns	
	1	Requires use of assistive devices (i.e. cane, w/c, walker, furniture, etc)	
I. Equipment Respond based on the presence of the following types of equipment: IV pole, SCD, foley, chest tube, NG tube, fetal monitor, oxygen tubing, etc. This list is non-inclusive and all types of equipment utilized for patient care should be considered.	0	None present	
	2	1-2 present	
	4	3 or more present	
		TOTAL SCORE	
		SIGNATURE	

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18. OTHER HEALTH CONCERNS NOT ADDRESSED ABOVE

19. IDENTIFIED PROBLEMS

20. IMMEDIATE DISCHARGE PLANS

21. ☐ BELONGING SEARCHED _____
Staff signature

_____
Signature/Credential Date Time completed

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