Providence HEALTH CARE

PATIENT ADMISSION HISTORY AND SCREENING

Date: _____

Nurses should initial sections when complete.

☐ Violence Risk: known history of violence, physically or verbally threatening.
If yes, initiate Violence Risk Alert (PHC-NF413)

DIAGNOSES FOR THIS ENCOUNTER (Admission) :		**INITIALS**
TEAM:		
ALLERGIES:	See completed Caution Sheet (PHC-PH047)	
CODE STATUS:	See completed Options for Care & Resuscitation / DNAR Orders (PHC-PH254)	
PRECAUTIONS:	☐ MRSA ☐ VRE ☐ CPO ☐ Airborne ☐ Droplet ☐ Neutropenia ☐ C DIFF ☐ GI ☐ Other:	
LANGUAGE(S):	☐ English ☐ Other:	
VISION	☐ No issues ☐ **Glasses** ☐ **Blind** ☐ Right ☐ Left ☐ **Implants/Glass Eyes** ☐ Right ☐ Left ☐ Devices with patient	
HEARING	☐ No issues ☐ **Impaired** ☐ Right ☐ Left ☐ **Hearing Aids** ☐ Right ☐ Left ☐ Devices with patient	
DENTURES	☐ None ☐ Upper ☐ Lower ☐ Partial ☐ Full ☐ Devices with patient	
MOBILITY AIDS	☐ None ☐ Cane ☐ Manual Wheelchair ☐ Walker ☐ Crutches ☐ Motorized Wheelchair ☐ Other: _____ ☐ Devices with patient	
PERSONAL BELONGINGS AND VALUABLES:	☐ No Personal Belongings/Valuables ☐ Patient declined ☐ Yes: Complete Patient Belongings Form (PHC-SE003)	

			INITIALS
Medication Management	In the last month, have you or anyone else changed what medicines you take or how you take the medicines (both prescription medicines and medicines you buy without a prescription)	☐ No changes / No medications taken ☐ Yes: Notify Physician	
	Do you ever have difficulty taking your medicines as prescribed? (e.g. Missed or skipped doses) ☐ No ☐ Yes	☐ No ☐ Yes: ☐ Concerns addressed and documented in Interdisciplinary Notes ☐ Referral to Clinical Pharmacist in SCM ☐ Notify Physician ☐ Other referral: _____	
	Comments/Exceptions:		
Functional Mobility	Have you fallen in the last 90 days (3 months)? ☐ No ☐ Yes	☐ Yes to any: Implement Universal Falls Prevention Practices (Safe Step) **AND** Complete Fall Risk Assessment and Care Plan (PHC-NF256) ☐ No to all: Low risk for Fall Implement Universal Falls Prevention Practices (Safe Step) Fall Risk Assessment and Care Plan not required at this time	
	In the past 2 weeks, have you had any trouble or needed help with the following:		
	Getting out of bed or out of a chair? ☐ No ☐ Yes		
	Getting dressed, bathing/showering or toileting? ☐ No ☐ Yes		
	Walking or getting around? ☐ No ☐ Yes		
	Climbing stairs? ☐ No ☐ Yes		
	Comments/Exceptions:		

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RESPIRATORY (e.g. COPD, asthma, TB, surgeries)	☐ No History ☐ If yes, specify:	**INITIALS**
CARDIOVASCULAR (e.g. hypertension, MI, irregular heart rhythm, surgeries, pacemaker)	☐ No History ☐ If yes, specify:	
ENDOCRINE (e.g. Diabetes, thyroid, surgeries)	☐ No History ☐ If yes, specify:	
GI / GU (e.g. digestive problems, nausea, cystitis, surgeries, possibility of pregnancy)	☐ No History ☐ If yes, specify: LMP: Last BM:	

Nutrition & Hydration

Have you lost weight in the last six months WITHOUT TRYING to lose weight	☐ No ☐ Yes	☐ Yes to BOTH of the questions: Enter a Dietitian referral in SCM
Have you been eating less than usual FOR MORE THAN A WEEK?	☐ No ☐ Yes	
Do you cough or choke when eating, or have trouble swallowing	☐ No ☐ Yes	☐ Yes: Complete Dysphagia Screening Tool (PHC-NF208)

Complete Dysphagia Screening Tool if:

- ☐ patient is age 70 or more
- ☐ patient is showing signs or symptoms of dysphagia at any time during their hospitalization
- ☐ patient has a neurological diagnosis within current admission
- ☐ patient has had head or neck surgeries/injuries or intubation of more than 48 hours
- ☐ patient has a history of COPD

Comments/Exceptions:

Bowel

Do you have any problems with your bowels?

- ☐ No
- ☐ Yes: Continue ***Bowel Function Screening***

Comments/Exceptions:

Bowel Function Screening

Do you have hard stools?	☐ No ☐ Yes
Do you have loose stools?	☐ No ☐ Yes
Do you have difficulty controlling bowel movements or gas?	☐ No ☐ Yes

- ☐ No to all
- ☐ Yes to any: Notify physician to assess further and document patient responses in nursing admission assessment.

  For nursing interventions refer to Bowel Protocol for PHC.

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PATIENT ADMISSION HISTORY AND SCREENING

			INITIALS
☐ Peritoneal Dialysis ☐ Hemodialysis			
Bladder	Do you have any problems passing urine? ☐ No ☐ Yes: Continue **Bladder Function Screening**	**Bladder Function Screening** Do you pass urine more than every 2 hours during the day? ☐ No ☐ Yes Do you get up more than twice a night to pass urine? ☐ No ☐ Yes Do you feel a need to rush to the toilet? ☐ No ☐ Yes Do you leak urine? ☐ No ☐ Yes YES to any: Notify physician to assess further and document patient responses in nursing admission assessment For nursing interventions refer to Urinary Catheters: Management for the Prevention of UTI; and Bladder Scanner Use standards	
	Comments/Exceptions:		
NEUROLOGICAL (e.g. stroke, TIA, headaches, surgeries, seizures)	☐ No History ☐ If yes, specify:		
MENTAL HEALTH (e.g. depression, anxiety, behavioural)	☐ No History ☐ If yes, specify:		
Cognitive Functioning	Have you (or family or friends) noticed any sudden changes in your: Behaviour (e.g. Have you felt more irritable or less social?) ☐ No ☐ Yes Thinking (e.g. Have you found it harder to focus or to plan familiar tasks?) ☐ No ☐ Yes Memory (e.g. Have you misplaced things or forgotten appointments?) ☐ No ☐ Yes Feelings (e.g. Have you felt sad most of the time?) ☐ No ☐ Yes	If YES to any: Has it affected your ability to live your everyday life? ☐ No ☐ Yes: Notify Physician to assess further and document patient responses in nursing admission assessment	
	Nurse to Assess: *Observe the* ***general appearance of the person*** *(e.g. hygiene, grooming, facial expression, demeanor, manner of dress), the* ***person's behaviour during the interview process*** *(e.g. eye contact, cooperativeness, body language, speech or manner of communication).* **IMPORTANT:** In the Mental Health Program, nursing will complete a mental status exam as part of the nursing admission assessment.	☐ No concerns ☐ The person's appearance and/or behaviour appear to be out of the norm for the situation, document in patient chart, and ask the attending physician/resident to further assess	
	Comments/Exceptions:		
Pain	Have you had pain or soreness in any part of your body in the past 2 weeks?	☐ No ☐ Yes: Complete the SBAR Pain Profile (PHC-NF031)	
	Nurse to Assess: *Does the patient have cognitive/language impairment and present with symptoms suggestive of pain?* ☐ No ☐ Yes	☐ If YES: Complete the SBAR Pain Profile (PHC-NF031) by obtaining collateral information from family and caregivers and completing a behavioural pain assessment tool; BPS (PHC-NF408) or PAINAD (PHC-NF383)	
	Comments/Exceptions:		

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SKIN/WOUND CARE: (e.g. pre-existing skin conditions, wounds)	☐ No History ☐ If yes, specify:	**INITIALS**
PRESSURE ULCER RISK SCREEN: Braden Scale and Pressure Ulcer Prevention Care Plan (PHC-NF393) completed on admission		
TOBACCO SCREEN: Have you used any tobacco products in the past 6 months?	☐ No ☐ Yes: Last use: _____ If used in the last 7 days offer Nicotine Replacement Therapy **Note: Nurse Initiated NRT may be initiated by RN staff only**	

ALCOHOL SCREEN: ☐ Alcohol Withdrawal Orders already initiated by MD (No further alcohol screening required)

When was your last alcoholic drink?
Date: _____ Time: _____
(If months or years, note best estimate)

☐ 7 or more days ago: No further screening required
☐ Less than 7 days ago: Complete ***CAGE Questionnaire***

CAGE Questionnaire:

Have you ever felt you needed to **C**ut down on your drinking?	☐ No	☐ Yes
Have people **A**nnoyed you by criticizing your drinking?	☐ No	☐ Yes
Have you ever felt **G**uilty about your drinking?	☐ No	☐ Yes
Have you ever felt you needed a drink first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-opener**)?	☐ No	☐ Yes

☐ Yes to 2 or more CAGE questions:
Initiate CIWA-Ar Flow Sheet (PHC-NF029) as per Nursing Alcohol Withdrawal Protocol
☐ CIWA Not Applicable
☐ CIWA initiated

DRUG SCREEN: Have you used any non-prescription, herbal or street drugs in the last month?	☐ No ☐ Yes: What? _____ Last use: _____ ☐ Notify Physician

DELIRIUM: Risk Factors (Check all that apply)

Patient/Environmental Risks:

- ☐ Age 75 or older
- ☐ Cognitive Impairment
- ☐ Previous Delirium
- ☐ History of Depression
- ☐ Alcohol/Drug Withdrawal
- ☐ Sleep Disturbance
- ☐ Vision/Hearing loss
- ☐ Functional Impairment
- ☐ Relocation
- ☐ Use of Restraints

Medical Risks:

- ☐ History of TIA or CVA
- ☐ Surgery/Anesthesia
- ☐ Electrolyte Imbalance
- ☐ Hypoxia
- ☐ Fever
- ☐ Bipolar
- ☐ Unrelieved Pain
- ☐ Hypotension
- ☐ Infection
- ☐ Multiple Co-morbidities
- ☐ Advanced Illness

Medication Risks:

- ☐ Receiving 5 or more meds
- ☐ Benzodiazepines
- ☐ Narcotic Analgesics
- ☐ Cardiac Drugs
- ☐ Antipsychotics
- ☐ Street Drug Use

☐ Patient has 3 or more risk factors:
Initiate CAM screening every 12 hours and initiate PRISME (See Delirium Screening and Care Plan (PHC-NF351)

☐ Patient has less than 3 risk factors:
DO NOT initiate CAM but continue to monitor for changes in risk factors and initiate appropriate PRISME interventions to mitigate risk.

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PATIENT ADMISSION HISTORY AND SCREENING

PSYCHOSOCIAL RISK SCREEN				INITIALS
Do you feel unsafe at home?	☐ No	☐ Yes	☐ Yes to any: Enter a Social Work Referral in SCM and document patient responses in Interdisciplinary Notes	
Are there people in your life that worry you?	☐ No	☐ Yes		
Do you have financial issues impacting your health?	☐ No	☐ Yes		
Do you currently have or need any help at home (e.g. with grocery shopping, making meals, housekeeping?)	☐ No	☐ Yes		
Are other people dependent on you for care or support?	☐ No	☐ Yes		

☐ No Fixed address ☐ Lives at home with: _____ # stairs at home: _____

Community supports used: _____ Hours of support used: _____

☐ Assisted Living ☐ Long Term Care

Comments/Exceptions:

SAFETY:	☐ Unit Safety Orientation complete ☐ Patient Safety: It's Everyone's Responsibility" pamphlet given	

OTHER COMMENTS:

HISTORY AND SCREENING COMPLETE: (Your signature only indicates that the form is complete, not that you completed the form)

Date	Time ∗	Printed Name	Signature and Designation	Initials

∗ It is imperative to note the time that this form is completed.
The Ministry of Health is auditing to ensure that screens are completed within 48 hours of decision to admit.