NURSING ASSESSMENT FORM:Name of HCC

Name:…….. Age/Sex:…….. Ward/Bed No.: ……

Hospital Reg. No.: ……..…..…..… Primary Language:……..…… Occupation: ……

Level of Education: ……..… Religion: ……..…… Marital Status: ……

ADMISSION DATA

Arrived Via: ☐ Wheel Chair ☐ Streacher ☐ Ambulatory

Admitted From: ☐ OPD ☐ ER ☐ Others……

Date & Time of Admission: ……

Admitting Doctor:……

Diagnosis:……

Chief Complaint:……..

Source of Information: ☐ Patient ☐ Attendant

VITAL SIGNS

BP: …… Pulse: …… RR: ……..……RBS:……

Temp: ……. SPO2:…… Pain:(Site: ……..Score:……)

Weight: …….. Height: …….. BMI: ……

ORIENTATION TO UNIT

	Yes	No		Yes	No
Nurses' Station	☐	☐	Visiting Hour	☐	☐
Toilet	☐	☐	Electrical Policy	☐	☐
Rules & Regulations	☐	☐	Bed Controls	☐	☐

MEDICATIONS

Patient on Medication: ☐ Yes ☐ No If Yes, Specify Below

	Drug Name	Dose/Freq.	Last Dose
1			
2			
3			
4			

Deposition of Meds: ☐ Home ☐ Nurse's Station ☐ Bedside

ALLERGIES

☐ No Known Allergies

☐ Drugs: ……

☐ Food/Others: ……

☐ Blood Transfusion: ……

Sign &Symptoms: ……

……

PAST HISTORY

☐ No Major Problem ☐ Neurological

☐ Cardiovascular ☐ Autoimmune

☐ Gastrointestinal ☐ Musculoskeletal

☐ Respiratory ☐ Psychiatric

☐ Genitourinary ☐ Gynae/Obs

☐ Endocrine ☐ Others……

☐ Surgical/Procedures:……

Date:……..

ASSERTIVE DEVICE

☐ None ☐ Prosthesis

☐ Wheelchair ☐ Glasses

☐ Cane/Crutches/Walker ☐ Contact Lens

☐ Pace maker ☐ Dentures

☐ Hearing Aids ☐ Others: ……

ASSISTANCE

Need Assistance with:

☐ Ambulation ☐ Meals ☐ Elimination

☐ Dressing ☐ Hygiene ☐ None

☐ Others: ……

NUTRITION

Appearence: ☐ Nourished ☐ Emanciated ☐ Obesed

Appetite: ☐ Good ☐ Fair ☐ Poor

Diet:……

Meal Pattern:……..

☐ Chealosis ☐ Bleeding Gum ☐ Muscle Wasting.

Recent Weight Changes: ☐ Present ☐ Absent

PSYCHOLOGICAL

Recent Stress: ☐ Yes ☐ No

Coping Mechanism:……..…

Support System:……....

Mood: ……..

HABITS

Alcohol Use: ☐ Yes ☐ No Since:……....

Tobacco Use: ☐ Yes ☐ No Since;……

Drug Use: ☐ Yes ☐ No Since:……....

NEUROLOGICAL

Orientation: ☐Person ☐ Place ☐ Time

☐ Sedated ☐ Alert ☐ Restless ☐ Drowsy

☐ Confused ☐ Lethergic ☐ Comatose

Pupils: ☐ Reactive ☐ Sluggish

☐ Equal ☐ Unequal ☐ Others:……

Paresthesia/Numbness: ☐ Present ☐ Absent Site:……

Speech: ☐ Clear ☐ Unclear ☐ Others: ……

GCS: E: …… V: …… M: …… Tot: ……/15

MUSCULOSKELETAL

History of Fractures: ☐ Yes ☐ No Site:……

Normal ROM of Extrimities: ☐ Yes ☐ No

Normal ROM of Neck: ☐ Yes ☐ No

☐ Weakness ☐ Paralysis

☐ Contractures ☐ Joint swelling

☐ Pain ☐ Others:……

RESPIRATORY

Breathing Pattern: ☐ Even ☐ Uneven ☐ Shallow

Dyspnea: ☐ Present ☐ Absent

Breathing Sound: ☐ Clear ☐ Others……

Cough: ☐ none ☐ Productive ☐ Non-Productive

Characteristics of Sputum: ……

CARDIOVASCULAR

Pulse:…… ☐ Regular ☐ Irregular

Pacemaker: ☐ Present ☐ Absent

Edema: ☐ Present ☐ Absent Site:……..

Perfusion: ☐ Warm ☐ Cold ☐ Diaphoretic ☐ Dry

Capillary Refill ☐< 2 Seconds ☐ > 2 Seconds

Chest Pain: ☐ Present ☐ Absent Others:……

GASTROINTESTINAL

Oral Mucosa: ☐ Normal ☐ Others: ……

Bowel Sound: ☐ Present ☐ Absent

Constipation: ☐ Present ☐ Absent

Diarrhoea: ☐ Present ☐ Absent

Abdominal Distention: ☐ Present ☐ Absent

Last Stool Passed & Character: ……..

Oestomy: ☐ Present ☐ Absent

GENITOURINARY

Urine Last Voided:……

Frequency: ☐ Normal ☐ Anuria ☐ Oliguria ☐ Polyuria

Hematuria: ☐ Present ☐ Absent

Dysuria: ☐ Present ☐ Absent

Incontinence/Retention: ☐ Present ☐ Absent

Catheter: ☐ Presnt ☐ Absent

Catheter Type: ☐ Condom ☐ Indwelling ☐ Suprapubic

LMP: …… ☐ Not Applicable ☐ Menopause

No. of Children: ……. Last Child Birth: …… ☐ NA

Vaginal/Penial Discharge: ☐ Yes ☐ No ……

SKIN ASSESSMENT

Colour: ☐ Normal ☐ Cyanosis ☐ Jaundice ☐ Erythema

☐ Pallor ☐ Others:……

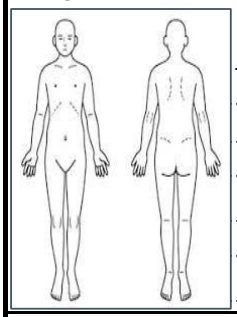
Rashes/Bruises: ☐ Present ☐ Absent ……

Lesions/Mass: ☐ Present ☐ Absent ……..……

Pressure Injury on Admission: ☐ Yes ☐ No

Site: …….. Stage: ……

Developed: ☐ Home ☐ Health Care Facility ……



General Skin Description

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PRESSURE INJURY "AT RISK" SCREENING(Norton's Scale)

Physical Condition	Good	4 □
	Fair	3 □
	Poor	2 □
	Very Poor	1 □
Mental Condition	Alert	4 □
	Apathetic	3 □
	Confused	2 □
	Stuporous	1 □
Activity	Ambulant	4 □
	Walk with help	3 □
	Chair Bound	2 □
	Bed Ridden	1 □
Mobility	Full	4 □
	Slightly Impaired	3 □
	Very limited	2 □
	Immobile	1 □
Incontinence	Normal	4 □
	Urinary Incontinence	3 □
	Fecal Incontinence	2 □
	Total Incontinence	1 □

Total Score: …….

RISK SCORE (more than 18-low risk) (14-18-medium risk) (10-14- high risk) (Bbelow 10-very high risk.)

PATIENT'S RISK FOR FALL SCREENING

JOHNS HOPKINS FALL RISK ASSESSMENT TOOL

If patient has any of the followings, check the box and apply interventions.

High Fall Risk: Implement High Fall Risk interventions as per protocol

☐ Hx of more than one fall within 6 months before admission

☐ Patient has expierenced fall during this hospitalization

☐ Patient is deemed high fall risk per protocol(Eg: seizures)

Low Fall Risk: Implement Low Fall Risk interventions as per protocol

☐ Complete Paralysis or completely immobilised

DO NOT CONTINUE WITH FALL RISK SCORING IF ANY OF THE ABOVE CONDITIONS ARE CHECKED

AGE	60-69	1	
	70-79	2	
	>80	3	
FALL HISTORY	1 fall within last 6 months before admission.	5	
ELIMINATION [BOWEL & BLADDER]	Incontinence	2	
	Urgency/Freq.	2	
	Urgency/Freq. & Incontinence	4	
MEDICATIONS [PCA/Opiates, Anticonvulsants, Diuretics,Antihypertensives ,Hypnotics,Laxatives, Sedatives, Psychotrophics]	On 1 Medicine	3	
	On 2 or more medicines	5	
	Sedated procedure within past 24 hrs.	7	
PATIENT CARE EQUIPMENTS	One Present	1	
	Two Present	2	
	Three or More Present	3	
MOBILITY	Requires Assistance for mobility, ambulation, etc	2	
	Unsteady Gait	2	
	Visual/auditory Impairment	2	
COGNITION	Altered Awareness of immediate physical awareness	1	
	Impulsive	2	
	Lack of Understanding of one's physical & cognitive limitations	4	

Total Score: ……...

<6: Low Fall Risk6-13: Moderate Fall Risk>13 High Fall Risk

PROBLEM LIST

1: ……

2: ……

3: ……

4: ……

5: ……

6: ……

NURSE

Sign: ……Date: ……..

Name: ……..

Designation: ……..BMHC Reg No: ……..