

## GENITOURINARY

**Bladder:**     **WNL**    **Urine Color:** \_\_\_\_\_

Continent                       Length of Incontinence

Aneuric                             Distention

Indwelling Catheter: Size: \_\_\_\_\_ Date of Insertion: \_\_\_\_\_

Suprapubic                       Intermittent Catheterization

**OTHER:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FEMALE:**

LMP..... Approximate Date: \_\_\_\_\_     Unknown

Menopause .....  Yes     No

Possibility of Pregnancy.....  Yes     No

Vaginal Discharge .....  Yes     No

Describe: .....  Yes     No

**MALE:**

Prostate Problems .....  Yes     No

Implants .....  Yes     No

Describe: \_\_\_\_\_

**EXPERIENCING:**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Urgency                  | <input type="checkbox"/> Frequency             | <input type="checkbox"/> Pain/Burning       | <input type="checkbox"/> Dysuria                               |
| <input type="checkbox"/> Continued Desire to Void | <input type="checkbox"/> Voids often (sm amts) | <input type="checkbox"/> Unable to Void     | <input type="checkbox"/> Difficulty Starting / Stopping Stream |
| <input type="checkbox"/> Dribbles _____           | <input type="checkbox"/> Bloody Urine          | <input type="checkbox"/> Lack of Perception | <input type="checkbox"/> Foul-Smelling Urine                   |
| <input type="checkbox"/> Other: (Specify:)        |  |   |  |

## PAIN & SLEEP

**PAIN DESCRIPTION:**

None                       Tingling                      Location: \_\_\_\_\_

Numb                       Continuous                      Relief Measures: \_\_\_\_\_

Burning                       Intermittent                      When Does it Occur and Duration? \_\_\_\_\_

Sharp                       Radiating                      Precipitating Factors: \_\_\_\_\_

Accompanying Symptoms: \_\_\_\_\_

**PAIN SCALE:** \_\_\_\_\_

0—2 =None to very mild

3—5 =Moderate

6—8 =Moderate to severe

9—10 =Severe to worst

**SLEEP PATTERN:**

Normal / Usual Bedtime: \_\_\_\_\_ Medication / Sleep Aids: \_\_\_\_\_

Normal / Usual Wake-Up Time: \_\_\_\_\_ Naps: Yes No If Yes, When? \_\_\_\_\_



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## FALL RISK ASSESSMENT

**DIRECTIONS:** Place a check mark in front of elements that apply to your patient. Those items followed by an asterisk will automatically place the patient at risk for falls. Other items will be considered in making the judgement to place patient at risk for falls and initiating the Fall Prevention Protocol.

|   |   |   |
|---|---|---|
| <p><b>MISCELLANEOUS</b></p> <p><input type="checkbox"/> History of falls *</p> <p><input type="checkbox"/> History of seizures</p> <p><input type="checkbox"/> Orthotic changes</p> <p><input type="checkbox"/> Recent amputation *</p> <p><b>PHYSICAL LIMITATION</b></p> <p><input type="checkbox"/> Weakness / Dizziness *</p> <p><input type="checkbox"/> Hemiparesis / Paralysis *</p> <p><input type="checkbox"/> Seizure disorder</p> <p><input type="checkbox"/> Impairment of vision</p> <p><input type="checkbox"/> Impairment of hearing</p> <p><input type="checkbox"/> Slow reaction time *</p> | <p><b>COMMUNICATION</b></p> <p><input type="checkbox"/> Inability or refusal to follow instructions *</p> <p><input type="checkbox"/> Inability or refusal to call for help *</p> <p><b>AMBULATION</b></p> <p><input type="checkbox"/> Cane, Crutches, Walker, Cast, Braces</p> <p><input type="checkbox"/> Up with Assistance</p> <p><b>ELIMINATION</b></p> <p><input type="checkbox"/> Diuretics / Laxatives</p> <p><input type="checkbox"/> Urinary urgency / Frequency</p> <p><input type="checkbox"/> Diarrhea</p> | <p><b>MEDICATIONS</b></p> <p><input type="checkbox"/> Hypotensive or CNS depressants</p> <p><input type="checkbox"/> Tranquilizer / Sedative</p> <p><input type="checkbox"/> Hypnotics *</p> <p><input type="checkbox"/> Analgesics</p> <p><b>MENTAL STATUS</b></p> <p><input type="checkbox"/> Confusion / Disorientation *</p> <p><input type="checkbox"/> Impaired memory or judgement *</p> |
| <p><input type="checkbox"/> <b>HIGH FALL RISK - Protocol Initiated</b>    Yes    No</p> <p><input type="checkbox"/> <b>LOW RISK AT THIS TIME</b></p>  |   |   |

**Comments:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RN Signature** \_\_\_\_\_

**Date** \_\_\_\_\_