

Patient identification validated and ID bracelet applied

GENERAL INFORMATION

Preferred Name:	Admission Time:	Room/Bed #:
Admitting Diagnosis:	Onset:	Secondary Diagnosis:
Primary Physician:	Arrived From:	
Marital Status: M S D W	Present Occupation:	
Consistent Contact Person:	Phone #:	
Alternate Contact Person:	Phone #:	
Primary Language:	Read, Write, and Understand English?	Yes No

ADVANCE DIRECTIVES

CODE STATUS

POAHC: Yes No Who?	Guardian: Yes No Who?	<input type="checkbox"/> Full Code
Living Will on chart? Yes No N / A (No living will)	Location of Living Will:	<input type="checkbox"/> Other (Specify)
Acknowledgement signed by Patient? Yes No Who?		

PATIENT VALUABLES

ORIENTATION

	Sent Home	To Bus. Ofc.	At Bedside	
Billfold/Purse/Money: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Buddy Book <input type="checkbox"/>
Jewelry: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Call Light System. <input type="checkbox"/>
Hearing Aid: Right Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Room Lights. <input type="checkbox"/>
Glasses/Contact Lenses: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meals <input type="checkbox"/>
Dentures: Upper Lower Partial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed Controls <input type="checkbox"/>
Clothing: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phones. <input type="checkbox"/>
Walker: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TV <input type="checkbox"/>
Wheelchair: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Side Rails. <input type="checkbox"/>
Cane: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visiting Policy. <input type="checkbox"/>
Prosthesis -Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoking Policy <input type="checkbox"/>
Medications: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BR Emergency Light <input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nearest Exit <input type="checkbox"/>
			Pharm	Fall Prevention Reviewed <input type="checkbox"/>
Patient/Family Signature: _____				

VITAL SIGNS

Vital Signs: TEMP PULSE AP / RAD (Circle one) RESP BP: Right Left
 Height: Weight: lbs. Scale Used: Bed Standing Wheelchair Sling Skin warm, dry: Yes No, Describe:

PRECAUTIONS

ALLERGIES: NKA Drug: (List Name / Reaction) Food: (List Name / Reaction)

Allergy Bracelet Applied: Yes No **LATEX ALLERGY: Yes No**

INFECTION STATUS:	<input type="checkbox"/> MRSA: Site : _____	TB SCREENING: 'Do you have any of the following?' Cough (>2 weeks) Yes No Bloody Sputum Yes No Unexplained weight loss Yes No Night Sweats Yes No	Do you have or ever have had TB? Yes No Does anyone in your immediate family have TB? Yes No Unsure Physician Notified Yes No
	<input type="checkbox"/> VRE: Site : _____		
	<input type="checkbox"/> CDIIF POS / NEG		

WT BEARING ABILITY: Non-WB Full WB Unknown

RN Signature _____ Date _____

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(Addressograph)