TOBACCO FREE CAMPUS

Welcome and thank you for choosing Northeast Georgia Health System for your health care needs.

- Information on "Patient Rights and Responsibilities" is available to all patients. If you are admitted, this information will be in the "Guide to Patient Services" in your room. If you are an outpatient, it will be posted in the area where you receive care.
- You should not keep any valuables with you in the hospital. The hospital vault is available if you need it. Northeast Georgia Medical Center is not responsible for any lost items.

Patient/family please fill out sections 1, 3 and 4. Please answer all questions as completely as possible.

Section 1 (Patient/family completes)

Date/Time: _____ Name Patient Prefers to be Called: _____

Person Completing Form: _____ Relationship: _____

Who do we call 1st in case of emergency: _____

Phone #: _____

Why are you seeking medical care? _____

Primary Physician: _____ Phone #: _____

Nutrition Screening:

Diet at home: ❑ Regular ❑ Other Describe: _____

YES	NO	
❑	❑	Have you had an **unplanned** weight loss? If yes, _____ pounds in _____ months.
❑	❑	Are you on tube feeding or feedings by I.V.?

OTHER:

❑	❑	Are you currently breast feeding or pregnant?

Personal Items: ❑ No Valuables

Please Check One	With You	Sent Home	Vault
❑ Glasses/contact lens			
❑ Hearing aid			
❑ Dentures, partial, retainer			
❑ Prosthesis			
❑ Money/credit cards			
❑ Personal equipment (cane, walker, brace, etc.)			
❑ Other valuables (jewelry, etc.)			

❑ Patient wishes to keep at own risk

Signature: _____

❑ Valuables sent home with: _____

_____

Signature: _____
(person taking valuables)

Relationship: _____

Section 2 (Nurse completes)

Allergies (food, drugs, latex, tape, other) List allergy and reaction: _____

_____

_____

_____

_____

_____

_____

❑ Participating in any Clinical Trials or Medical Research. List: _____

_____

Pharmacy Used: (name, phone): _____

❑ Fax meds and allergies to pharmacy.

See "Home Medication List and Discharge Instructions"

❑ **INFORM PATIENT NOT TO TAKE OWN HOME MEDS**

Height: _____ ❑ actual ❑ stated

Weight: _____ lbs _____ kgs

BP: _____ T: _____

P: _____ R: _____

❑ I.D. band in place. O_2 Sat _____

❑ Allergy band if applicable

ADVANCED DIRECTIVES

Has the patient ever signed an Advanced Directive: ❑ Yes ❑ No

❑ The patient has signed an A.D. and a copy is on the chart

❑ The patient has signed an A.D. but did not bring a copy—Name of person instructed to bring AD _____

❑ Patient requested information regarding A.D. and case mgmt./social services was notified of the request.

● Inpatient orientation to room includes: "Guide to Patient Services," Patient Education TV, Advanced Directives and Patient Rights, Smoking Cessation, Visiting Hours, Tobacco Free Campus, bed, lights, nurse call light, emergency bathroom light and telephone.

Disposition of home medications:

❑ No meds taken at home
❑ None brought in
❑ Meds sent to pharmacy in valuables envelope
❑ Family to bring

❑ Meds sent home with: _____

Signature of Person taking meds home: _____

Relationship: _____

PATIENT IDENTIFICATION:

Northeast Georgia Medical Center

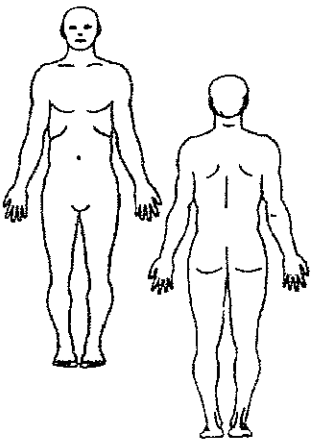
ASSESSMENT DATABASE

1332

NGMC FORM # 1332 (1/07)

Section 3 (Patient/family completes)

Pain Assessment



YES NO

❑ ❑ 1. Do you have pain now? (If no, skip to the next section)

❑ ❑ 2. Does anything (other than medication) make your pain better?
If yes, please explain: _____

❑ ❑ 3. Does anything make your pain worse?
If yes, please explain: _____

4. How does pain affect your lifestyle? Explain: _____

5. Where is your pain? You may also use the pictures to color in the area where you have pain.

6. How long have you had this pain? _____

Coping / Stress / Spiritual

YES NO

❑ ❑ 1. **Religious/Cultural:** Do you have beliefs or customs that may affect how we care for you (medications, foods, blood transfusions, religious needs, etc. during hospitalization)? If Yes, explain: _____

❑ ❑ 2. **Stressors:** Have you had any recent major life changes or concerns? If yes, how have you been dealing with them?: _____
How can we help?: _____

❑ ❑ 3. **Social:** Are you in a relationship where someone may try to harm you? _____

Foreign Bodies / Implanted or Special Devices: *Do you have any of the following:*

YES NO

❑ ❑ 1. Implanted devices (such as pacemaker, pumps, nerve stimulators, heart valve, shunts or ports, artificial joint, pins, screws, clips or staples)? If yes, list: _____

❑ ❑ 2. Metal foreign bodies such as bullets or other metal particles or body piercing? If yes, list: _____

Interdisciplinary Functional Screening: *Do you currently have any problems with:*

YES NO

❑ ❑ 1. Balance or walking (PT)

❑ ❑ 2. Weakness of your arm(s) or leg(s) (PT, OT)

❑ ❑ 3. Bathing, dressing, feeding, or toileting (OT)

❑ ❑ 4. Coughing, choking, or trouble swallowing when eating or drinking (SLP)

❑ ❑ 5. Communication: problem with understanding, memory, or speaking (SLP)

Discharge Planning / Case Management / Social Services

1. Who do you live with? Name: Relationship: Phone Number:

2. Who should be involved with your discharge plans? ❑ See above or list
Name: Relationship:
Day Phone: Evening Phone: Other contact person / phone:

3. Where do you live? ❑ Home/Apartment ❑ Personal Care Home/Nursing Home (name):
❑ Other:

YES NO

❑ ❑ 4. Do you have someone to help you at home after you leave the hospital?

❑ ❑ 5. Do you use medical services at home? ❑ Home Health Care ❑ Oxygen
List any medical equipment you have at home:

Learning Needs

1. How do you learn best? ❑ Reading ❑ Listening ❑ Video ❑ Hands-on ❑ Other: _____

2. Do you read, write, and understand English? ❑ yes ❑ no _____
If language barrier, List Language: _____

MEDICAL HISTORY — Section 4 (Patient / family completes)

	Yes	No	Do you have or have you ever had: *If you answer yes, please circle what applies to you*
Ortho / Neuro	❑	❑	Stroke / muscle weakness / paralysis
	❑	❑	Seizure / epilepsy
	❑	❑	Dizziness / frequent headaches / head injury
	❑	❑	Back / neck / hip / knee problems / fractures / broken bones or arthritis
	❑	❑	Mental / emotional problems / depression (describe:_____)
Vision / Hearing	❑	❑	Problems with vision or hearing (glasses / contacts / hearing aids) (list: _____)
Cardiac	❑	❑	High blood pressure / low blood pressure
	❑	❑	Heart problems / heart failure / valve problems / pacemaker / heart murmur / mitral valve prolapse
	❑	❑	Angina / chest pain / heart attack (What Year?:_____)
	❑	❑	Swelling of hands / abdomen / feet or legs?
	❑	❑	**Recent EKG:** _____
Pulmonary	❑	❑	Asthma / emphysema / bronchitis / chronic cough / sleep apnea (CPAP use at home: ❑ Yes ❑ No)
	❑	❑	Short of breath when resting / when exercising / when lying flat / Do you sleep propped up or in a chair?
	❑	❑	Pneumonia
	❑	❑	Current tobacco user: (type:_____) (how much:_____) (how long:_____)
	❑	❑	Former tobacco user: Date Quit: _____. "Smoking Cessation Education" handout located in "Guide to Pt. Services."
Blood	❑	❑	Anemia / bleeding problems / blood clotting problems / blood clots (where:_____)
	❑	❑	Blood transfusion (when:_____)
	❑	❑	If you are having surgery, have you donated any blood or blood products for surgery?
			If yes (Date:_____Where:_____)
Endocrine	❑	❑	Diabetes controlled with diet / pills / insulin shots
	❑	❑	Thyroid disease or goiter
Renal	❑	❑	Kidney stones / frequent infections / bloody urine
	❑	❑	Kidney failure (how long:_____) (dialysis location:_____) (schedule:_____)
	❑	❑	Difficulty with urination / prostate problems
Gastro	❑	❑	Jaundice / cirrhosis
	❑	❑	Hepatitis (type:_____)
	❑	❑	Alcohol user / beer / wine / liquor (how much/often:_____) (how long:_____)
	❑	❑	Street drug user / marijuana / cocaine (type:_____) (how long/often:_____ /_____)
	❑	❑	Stomach ulcer / colitis / stomach problems / hiatal hernia / antacids / acid reflux
	❑	❑	Bowel movement (how often:_____) (last time:_____)
Oncology	❑	❑	Cancer (where:_____) (when:_____) (treatment:_____)
	❑	❑	Unidentified lumps or masses you are concerned about (where:_____)
Infection Control	❑	❑	TB or exposure to a person with TB / Coughing up blood
	❑	❑	Infection / infectious disease / sexually transmitted disease (list:_____)
	❑	❑	Wounds / rashes / lesions / shingles / herpes (location:_____)
			(other:_____)
Female	❑	❑	Pregnant / breast feeding / last menstrual period (date:_____)
	❑	❑	Recent breast changes (list:_____)
Other Significant Medical History			Other medical history or anything else we should know about your health including injury, trauma, car accident, gunshot or stab wounds. _____
Surgery History	❑	❑	Surgery: any reaction with anesthesia with you or family member, if yes please list: _____
	❑	❑	List all surgeries and dates: _____
	❑	❑	Do you have any caps / crowns / bridges / dentures / loose teeth
Family History			Has a parent / brother / sister / child / grandparent ever had:
	❑	❑	Heart disease / heart attack
	❑	❑	High blood pressure
	❑	❑	Cancer
	❑	❑	Stroke
	❑	❑	Diabetes

PATIENT IDENTIFICATION:

Section 5 (Nurse Completes)

Date/Time: _____ Reassessment Date/Time: _____

COGNITIVE / PERCEPTUAL

LOC ❑ Alert/Age ❑ Confused ❑ Forgetful ❑ Agitated ❑ Oriented /Age ❑ No Response To Stimulation ❑ Lethargic ❑ Asleep ❑ Recognizes Family ❑ Mentally/Physically Delayed ❑ Developmentally Delayed

Comm. ❑ No difficulty ❑ Difficulty expressing ❑ Age Appropriate ❑ Age Inappropriate ❑ Difficulty understanding ❑ Age Inappropriate ❑ Slurred Speech ❑ Impaired vision ❑ Impaired hearing ❑ Language barrier

Emotional Status ❑ Calm ❑ Irritable ❑ Apathetic ❑ Anxious ❑ Angry ❑ Sad ❑ Fearful ❑ Labile ❑ Withdrawn ❑ Other: _____

❑ No Change in system assessment
❑ Change (describe):

Pain ❑ Denies ❑ Present: Location: _____
Pt. Description: _____
Duration: ❑ Constant ❑ Intermittent ❑ Aching ❑ Sharp
❑ Numb ❑ VAS score (0-10) _____
❑ Burning ❑ Dull ❑ Tingling
Non-verbal Indicators: _____
Relief related pain intervention: ❑ Yes ❑ No

Pain ❑ Denies ❑ Present: Location: _____
Pt. Description: _____
Duration: ❑ Constant ❑ Intermittent ❑ Aching ❑ Sharp
❑ Numb ❑ VAS score (0-10) _____
❑ Burning ❑ Dull ❑ Tingling
Non-verbal Indicators: _____
Relief related pain intervention: ❑ Yes ❑ No

OXYGENATION / VENTILATION / TISSUE PERFUSION

Resp. ❑ No distress ❑ Irregular: _____ ❑ Dyspnea at rest ❑ Dyspnea on exertion

Lung Sounds ❑ Clear/equal ❑ Wheezes ❑ Coarse ❑ Rhonchi ❑ Diminished ❑ Crackles/Rales ❑ Absent
Location: _____

Cough ❑ Absent ❑ Productive: Color: _____ ❑ Nonproductive Amt/Consistency: _____

O_2 Therapy ❑ N/A ❑ Nasal cannula _____ L/M
O_2 Sat: _____% ❑ Mask: _____ % ❑ Trach collar: _____ % ❑ Nebulizer: _____

Apical Pulse ❑ Regular ❑ Irregular ❑ Tachycardia ❑ Bradycardia ❑ Telemetry: _____ ❑ Extra Heart Sounds/Murmurs

Cap Refill ❑ ? 3 seconds ❑ ? 3 seconds

Color ❑ Normal ❑ Pale ❑ Flushed ❑ Ashen ❑ Cyanotic ❑ Jaundice ❑ Other: _____

Edema ❑ None Pitting: ❑ +1 ❑ +2 ❑ +3 ❑ +4 ❑ Nonpitting Location: _____

Homan's ❑ Negative ❑ Positive ❑ Right ❑ Left ❑ NA

❑ No Change in system assessment
❑ Change (describe):

NUTRITION / ELIMINATION

Appetite ❑ Good ❑ Fair ❑ Poor Nausea: Frequency: _____

Abdomen ❑ Soft ❑ Firm ❑ Distended ❑ Tender

Bowel Sounds ❑ Normoactive ❑ Hyperactive ❑ Hypoactive ❑ Absent

Stools ❑ No stool ❑ Formed ❑ Hard/Difficult ❑ Not observed ❑ Loose ❑ Incontinent ❑ Ostomy: (type) _____

Urine ❑ Clear ❑ Cloudy ❑ Incontinent ❑ Yellow ❑ Dysuria ❑ Bloody ❑ Amber ❑ Frequency ❑ Foley ❑ Not observed: _____

❑ No Change in system assessment
❑ Change (describe):

INTEGUMENTARY

Mucous Memb. ❑ Moist ❑ Dry ❑ Intact ❑ Cracked ❑ Sores

Skin ❑ Warm ❑ Cool ❑ Hot ❑ Dry ❑ Diaphoretic ❑ Elastic ❑ Tenting ❑ Intact ❑ Decubitus Stage: ❑ I ❑ II ❑ III ❑ IV Location: _____

Dressing ❑ None ❑ Dry & Intact ❑ Changed

Incision Wound ❑ N/A ❑ Not Observed ❑ Sutures/Staple ❑ Well Approximated ❑ Sutures/Staple: ❑ Intact ❑ Removed
❑ Redness: ❑ Absent ❑ Present ❑ Swelling: ❑ Absent ❑ Present
❑ Drainage: Color: _____ Amount: _____
Drains: 1. Location: _____ Drainage: _____
2. Location: _____ Drainage: _____

❑ No Change in system assessment
❑ Change (describe):

MOBILITY

Extremity ROM ❑ Full ❑ Active ❑ Muscle/Joint Problems ❑ Spastic ❑ Flaccid
❑ Limitations: _____

RN Signature (for assessment)

❑ No Change in system assessment
❑ Change (describe):

RN Signature (for reassessment)

CONSULTS / REFERRALS

Infection Control: ❑ LTC patient, MRSA screen ❑ Hemodialysis patient, MRSA & VRE screen

❑ **Falls Risk Score:** Score: _____ SOP implemented for score > 5

❑ **Skin Risk:** Score: _____ Score ≤ 12, notify WOC

❑ **Nutrition Screening:** Notify Nutrition Services of any "yes" answers.

❑ **Functional Screening:** MD notified of any "yes" responses if indicated per guidelines

❑ **Educational Referrals:** (list) _____

❑ **Diagnosis Notification:** (Enter in Case Management in CPAC): ❑ Acute MI ❑ CVA ❑ CHF ❑ Community Acquired Pneumonia (CAP)

Notifications entered in CPAC by: **Signature** _____ **Date** _____ **Time** _____

❑ **See CRITICAL CARE FLOWSHEET**

*Unable to assess at this time due to: _____

Learning needs identified by RN (list at least one): _____

❑ SOC/pathway implemented on admission. See SOC for Nursing Diagnosis or: _____

Additional comments / notes:

• Immunization Protocol to be completed at time of Admission.

RN signature indicates that: (1) All areas are completed and have been reviewed by the RN and (2) the RN performed the Initial Physical Assessment. (3) Patient/Family were provided with and informed of "Guide to Patient Services".

Date: _____ **Time:** _____

RN Signature: _____