PROOF

Patient Name or Label

NURSING ASSESSMENT – ADULT SERVICE

Admission Date: _____ Time: _____ Age: _____ Sex: ☐ Female ☐ Male

B/P sitting: _____ Standing: _____ Pulse: ____ Resp: ____ Temp: ____ HT: ____ WT: ____

Allergies/Reaction: _____

Medication: _____

Environment: _____

Food: _____

Allergy Wrist Band on ☐ ☐ Medication ☐ Food ☐ Dietary Notified

Known Advance Directives: ☐ Yes ☐ No If yes, copy in chart: ☐ Yes ☐ No

Informed of Patient Rights (in an understandable language)? ☐ Yes ☐ No – If no, Explain: _____
Patient Rights Booklet Provide: ☐ Yes ☐ No

☐ Inpatient ☐ Accompanied by: ☐ Family ☐ Self ☐ Guardian (name): _____

☐ Voluntary ☐ Involuntary Copy of Guardianship: ☐ Yes ☐ No

Durable Power of Attorney ☐ Yes ☐ No ☐ Unknown

Admitted from: ☐ ER ☐ Screening/Crisis Center ☐ Private Providers' Office ☐ Home

Ambulatory? ☐ Yes ☐ No ☐ If no, explain: _____

REASON FOR HOSPITALIZATION: (In patient's own words)

_____

_____

Communication/sensory difficulties? ☐ reading ☐ writing ☐ vision ☐ speech ☐ hearing

☐ taste ☐ smell ☐ touch ☐ contact lenses ☐ glasses ☐ hearing aid

☐ requires interpreter (type) _____ ☐ N/A

Comments: _____

PAIN ASSESSMENT:

Physical discomfort? ☐ Yes ☐ No Location: _____

Onset: ☐ Gradual ☐ Sudden ☐ Other _____

Intensity (0-10) _____ ☐ Duration _____

Comments: _____

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Patient Name or Label

MEDICATIONS: PRESCRIBED/OTC/HERBALS:

SEE MEDICATION RECONCILIATION FORM

BRIEF SUBSTANCE USE HISTORY:

Have you used any non-prescribed substances in the last 48-72 hours? ☐ No ☐ Yes

What? _____ How much? _____ Last use: _____

Have you used alcohol excessively in the past 48-72 hours? ☐ No ☐ Yes – How much? _____ Last use: _____

Have you ever experienced: ☐ Withdrawal symptoms ☐ Seizures ☐ Delirium Tremors ☐ Other: _____

HISTORY OF PAST PSYCHIATRIC PROBLEMS: ☐ Yes ☐ No

Hospitalizations: ☐ Yes ☐ No How many? _____

Last admission?: _____ Where: _____

Reason: _____

_____

PHYSICAL ASSESSMENT:

SKIN ASSESSMENT

☐ No Problem

☐ Itching	☐ Cool	☐ Rash	☐ Drainage
☐ Petechia	☐ Ecchymosis	☐ Abscess	☐ Hirtuisum
☐ Flushed	☐ Poor Turgor	☐ Moist	☐ Edema
☐ Hot	☐ Skin Color: _____	☐ Diaphoretic	☐ Loss of Hair
☐ Decubiti/Pressure Ulcer	☐ Needle Tracts	Hair Color: _____	Eye Color:_____

Describe abnormal findings: _____

_____

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RESPIRATORY ASSESSMENT

☐ No problem ☐ Dyspnea ☐ Tachypnea ☐ Bradypnea ☐ Shallow
☐ Diminished ☐ Cough ☐ Labored ☐ Rales ☐ Rhonchi
☐ Wheezing ☐ Cyanotic ☐ Other ☐ Shortness of Breath

Describe abnormal findings: _____

CARDIOVASCULAR ASSESSMENT

☐ No problem ☐ Tachycardia ☐ Bradycardia ☐ Irregular ☐ Edema ☐ Orthostatic Hypotension
☐ Pacemaker ☐ Chest Pain ☐ Fatigue ☐ Heart Murmur ☐ Hypertension ☐ History of Falling

Describe abnormal findings: _____

EENT ASSESSMENT

☐ Blind
☐ No problem ☐ Vision Impaired ☐ Glasses ☐ Contact Lenses ☐ with patient ☐ Yes ☐ No
☐ Redness ☐ Hearing Impaired ☐ Deaf ☐ Hearing aid ☐ with patient ☐ Yes ☐ No
☐ Tinnitus ☐ Other

Describe abnormal findings: _____

NEUROLOGICAL ASSESSMENT

☐ No problem ☐ Weakness ☐ Dizziness ☐ Vertigo ☐ Numbness
☐ Tingling ☐ TICS ☐ Headaches ☐ Seizures ☐ Tremors
☐ Head Trauma ☐ Lethargic ☐ Confusion ☐ History of Stroke
☐ Speech Difficulty ☐ Multiple Sclerosis ☐ Other

Describe abnormal findings: _____

GASTROINTESTINAL ASSESSMENT

☐ No problem ☐ Regular ☐ Constipation ☐ Diarrhea ☐ Frequency _____
☐ Nausea/Vomiting ☐ Wt. Gain/Loss How Much? _____ Over what period? _____ ☐ Purge ☐ Anorexia ☐ Bulimia
☐ Difficulty Swallowing ☐ Difficulty Chewing ☐ Encoporesis ☐ Binge
☐ Dehydration ☐ Dietary Supplements ☐ Appetite Change

Appetite: ☐ Good ☐ Fair ☐ Poor ☐ Appetite Increased ☐ Appetite Decreased

Diet: ☐ Regular ☐ Low Sodium ☐ Low Fat ☐ Low Cholesterol ☐ ADA ☐ Pureed

Last Dental Exam: (date) Dentist: _____ Phone: _____

Describe abnormal findings: _____

NUTRITION ASSESSMENT

SEE NUTRITIONAL SCREENING

MUSCLE SKELETAL ASSESSMENT

☐ No problem ☐ Deformity ☐ Arthritic ☐ Limited Range of Motion ☐ Prosthesis

Devices used: ☐ Wheelchair ☐ Cane ☐ Walker

☐ Ambulatory ☐ Joint Replacement ☐ Other / Comments: _____

Describe abnormal findings: _____

GENITOURINARY ASSESSMENT

☐ No problem ☐ Pain on Urination ☐ Frequency ☐ Hesitancy

☐ Dysuria ☐ Hematuria ☐ Enuretic ☐ Incontinence Last PAP/Prostate Exam/PSA _____

☐ Discharge ☐ Genital Lesions ☐ Nocturia ☐ Sexually Transmitted Diseases

GYNECOLOGICAL ASSESSMENT

Last Menses: _____

☐ Possibility of Pregnancy ☐ Tubal Ligation ☐ Hysterectomy ☐ Menopause

Breasts: ☐ Lactating ☐ Nipple Discharge Last Mammogram: _____ Last Self Breast Examination: _____

☐ Estrogen Replacement Therapy

Describe abnormal findings: _____

PROOF

Patient Name or Label

ENDOCRINE ASSESSMENT:

☐ IDMM ☐ NIDDM ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Other

Blood Glucose Level: _____

Comments:

SLEEPING/ REST PATTERN

☐ No Problem ☐ Difficulty falling asleep ☐ Sleepwalking ☐ Early AM Waking

☐ Fear associated with sleep ☐ Nightmares ☐ Frequent Awakening

☐ Sleep enhancers: 1)_____, 2) _____

☐ Hours of sleep per night: _____ ☐ Does patient feel rested after sleep? ☐ Yes ☐ No

Comments:

SELF CARE:

Personal Hygiene/Activities of Daily Living	☐ Independent	☐ Dependent	☐ Describe Assistance required:
Toileting:	☐ Independent	☐ Dependent	☐ Describe Assistance required:
Care for personal environment:	☐ Independent	☐ Dependent	☐ Describe Assistance required:
Ambulation:	☐ Independent	☐ Dependent	☐ Describe Assistance required:
Eating/Nutrition:	☐ Independent	☐ Dependent	☐ Describe Assistance required:

Comments:

PROOF

Patient Name or Label

FALL RISK ASSESSMENT:

Fall Precautions initiated? ☐ Wrist Band on ☐ **SEE HENDRICH FALL ASSESSMENT TOOL**

FAMILY HISTORY:

Medical History: _____

Psychiatric History: _____

MENTAL STATUS:

Appearance: ☐ Well Groomed ☐ Clean/Neat ☐ Body Odor ☐ Inappropriate ☐ Disheveled

Speech: ☐ Fluent ☐ Slow ☐ Slurred ☐ Soft ☐ Loud
☐ Rapid ☐ Pressured ☐ Perseverative ☐ Incoherent ☐ Mute

Motor: ☐ Normal ☐ Restless ☐ Hyperactive ☐ Hypoactive ☐ Tremors ☐ Atypical Posture/Gate

Orientation: ☐ Person ☐ Place ☐ Time ☐ Situation

Attention/Concentration: ☐ Intact ☐ Variable ☐ Impaired

Short Term Memory: ☐ Intact ☐ Variable ☐ Impaired
Long Term Memory: ☐ Intact ☐ Variable ☐ Impaired

Mood: ☐ Euthymic ☐ Depressed ☐ Anxious ☐ Angry/Irritable ☐ Euphoric ☐ Manic

Affect: ☐ Appropriate ☐ Labile ☐ Constricted ☐ Flat ☐ Blunted

Thought Process: ☐ Logical/coherent ☐ Circumstantial ☐ Tangential
☐ Loose Association ☐ Flight of Ideas ☐ Confused

Thought Content: ☐ Appropriate ☐ Ideas of Reference ☐ Delusions ☐ Obsessive
☐ Phobic ☐ Paranoid

Perceptual Disturbance: ☐ None ☐ Auditory ☐ Visual ☐ Olfactory ☐ Tactile

Delusions: ☐ Yes ☐ No

Clinical Impressions: _____

PROOF

Patient Name or Label

HENDRICH II FALL RISK MODEL

RISK FACTOR	RISK POINTS	
CONFUSION/DISORIENTATION	4	☐
DEPRESSION	2	☐
ALTERED ELIMINATION	1	☐
DIZZINESS/VERTIGO	1	☐
GENDER (MALE)	1	☐

---

2 ☐

Any administered/prescribed antiepileptics (anticonvulsants):
(carbamazepine, divalproex sodium, ethotoin, ethosuximide, felbamate, fosphenytoin gabapentin, lamotrigine, mephenytoin, methsuximide, phenobarbitol, phenytoin, primidone, topiramate, trimethadione, valproic acid)

Any administered/prescribed benzodiazepine; **1** ☐
(ALPRAZOLAM, LORAZEPAM, MIDAZOLAM, OXAZEPAM, TRIZOLAM)

TOTAL POINTS: _____

GET-UP AND-GO* TEST: "RISING FROM CHAIR" (SELECT ONE)

- *IF UNABLE TO ASSESS (UNCONSCIOUS, DRUG-INDUCED COMA, TRACTION,*
- *EXTREME DEBILITATION/ATROPHY),MONITOR FOR CHANGE IN ACTIVITY LEVEL AND USE ALL OTHER RISK FACTOR SCORES.*

- *ABLE TO RISE IN A SINGLE MOVEMENT* 0 ☐
- *PUSHES UP, SUCCESSFUL IN ONE ATTEMPT* 2 ☐
- *MULTIPLE ATTEMPTS BUT SUCCESSFUL* 3 ☐
- *UNABLE TO RISE WITHOUT ASSISTANCE* 5 ☐

TOTAL (7 OR GREATER=HIGH RISK) ***TOTAL POINTS:_____***

PROOF

Patient Name or Label

SUICIDE RISK ASSESSMENT:

Present suicidal ideation, thoughts of self harm, thoughts of death/dying ☐ Yes ☐ No

Describe _____

Ability to exercise control over suicidal thoughts ☐ Yes ☐ No How many? _____

History of suicide attempts/gestures ☐ Yes ☐ No

Method used:

☐ Hanging ☐ Gunshot ☐ Overdose ☐ Carbon Monoxide ☐ Jumping off Bridge

☐ Stabbing ☐ Cut wrists ☐ Electrocution ☐ Refusing to eat ☐ Ingesting Toxic Substance

☐ Inhaling ☐ Self mutilation ☐ Reckless Driving ☐ Other _____

Family History of suicide ☐ Yes ☐ No

☐ Parent ☐ Sibling ☐ Grand Parent ☐ Aunt/Uncle ☐ Daughter ☐ Son ☐ Cousin

Method used:

☐ Hanging ☐ Gunshot ☐ Overdose ☐ Carbon Monoxide ☐ Jumping off Bridge

☐ Stabbing ☐ Cut wrists ☐ Electrocution ☐ Refusing to eat ☐ Ingesting Toxic Substance

☐ Inhaling ☐ Self mutilation ☐ Reckless Driving ☐ Other _____

Patient access to a gun? ☐ Yes ☐ No If yes, describe_____

If yes, physician notified? ☐ Yes ☐ No If yes, social work notified? ☐ Yes ☐ No

Informed by: _____ Date: _____

Henry Ford Behavioral Health is here to provide a safe environment for our patients. Our goal is to help you maintain control of your behavior and prevent the need for any use of restraints or seclusions. To assist us with this goal, please answer the following questions (your family or staff member may help you).

1. What makes you angry? _____

_____

_____

2. Have you ever been put in a room and physically prevented from leaving (seclusion)?
☐ No ☐ Yes If yes, explain: _____

_____

_____

3. Have you ever been so upset that you had to be physically restrained or received medication to help calm you? ☐ No ☐ Yes If yes, explain:_____

_____

_____

4. Is there anything that we can do to help calm you when you are upset?
☐ No ☐ Yes If yes, explain what calms you down when you are upset. _____

_____

_____

5. Do you have a physical disability?
☐ No ☐ Yes If yes, explain the nature of your disability.

6. Have you ever been physically hurt or sexually abused? ☐ No ☐ Yes If yes, explain:

_____

_____

Patient Signature:_____ Date:_____

Staff Signature/Title _____ Date:_____

BEHAVIORAL HEALTH SERVICES
KINGSWOOD HOSPITAL

PROOF

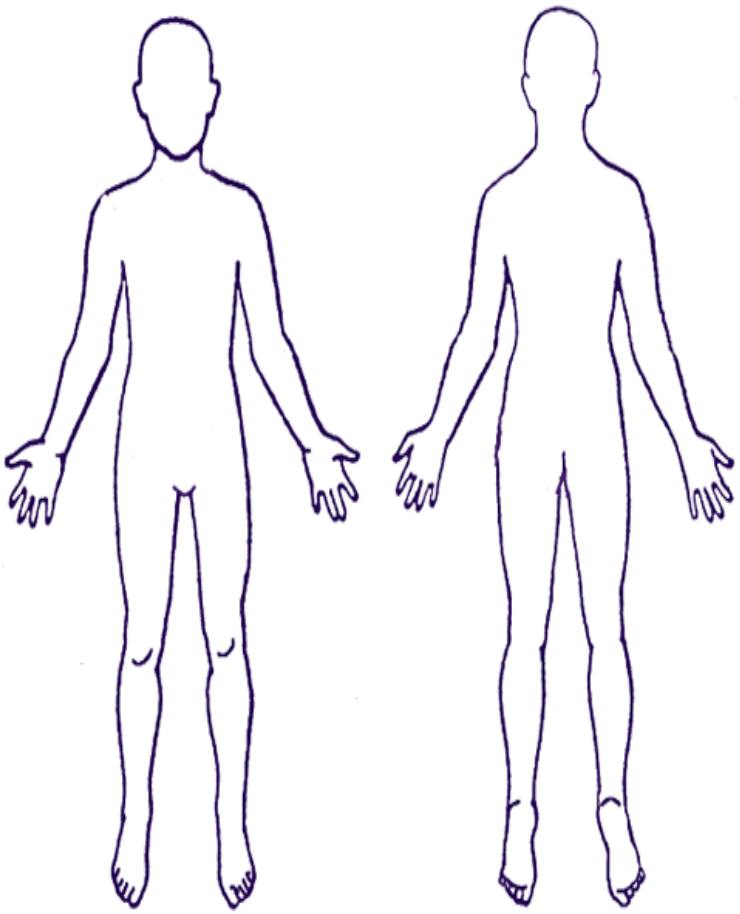
Patient Name or Label

PERSONAL SEARCH & PROPERTY LIST:

☐ Hearing Aids ☐ Glasses ☐ Contact Lens ☐ Medical Equipment

☐ Walker ☐ Wheelchair ☐ Crutches ☐ Prosthesis

☐ Braces ☐ Orthodontic Appliance ☐ Dentures ☐ Upper ☐ Lower ☐ Partial



VISUAL BODY CHECK

Indicate condition of skin by marking the body drawing with the appropriate code letters to indicate problem areas.

☐ BR = Bruise ☐ R = Rash

☐ BU = Burn ☐ S = Scar

☐ C = Contusion ☐ ST = Stitches

☐ D = Decubitus ☐ TA = Tattoo

☐ L = Laceration ☐ TM = Track Marks

☐ W = Wound ☐ A = Amputation

Comments:

☐ Patient Searched for Contraband?

Contraband found:
☐ No ☐ Yes
(If yes, list items)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature(s) of Staff Completing Personal Search:

1.) _____ 2.) _____

BEHAVIORAL HEALTH SERVICES
KINGSWOOD HOSPITAL

PROOF

Patient Name or Label

EDUCATION NEEDS:

☐ Patient ☐ Family / Significant Other

☐ Diagnosis ☐ Basic health practices (Activities of Daily Living) ☐ Medications ☐ Community Resources ☐ Safety

☐ Nutrition ☐ Plan of care, treatment and services ☐ Medical condition ☐ Medical equipment or supplies

☐ Pain/pain management ☐ Smoking Cessation

Where does patient get his/her source of health information: _____

Discharge needs of the patient: _____

Staff Signature/Title:	**Date:**	**Time:**