

INITIAL NURSING ASSESSMENT

PRIORITY

1  2  3

PATIENT NAME Jane Doe START OF CARE 5/2/16 MALE  FEMALE   
 ADDRESS 97 Bell Drive TELEPHONE 923-716-8142  
 PRIMARY CARE GIVER Husband TELEPHONE 276-276-8132  
 EMERGENCY CONTACT Mr. Smith TELEPHONE 426-426-2154  
 PLAN ACA MEMBER ID NUMBER 29764 MEDICAID ID NUMBER 2437621

AUTHORIZED PRACTITIONER INFORMATION

Primary Physician <u>DR Blue</u>	Specialty <u>Gastro</u>
Address <u>44 West DR.</u>	Phone # <u>276-137-2976</u>
Secondary Physician <u>Dr Young</u>	Specialty <u>Cardio</u>
Address <u>92-37 Linden BLVD</u>	Phone # <u>277 926-1376</u>
Hospital of Choice <u>Memorial</u>	

MEDICAL HISTORY/INFORMATION

Diagnosis	Onset	Diagnosis	Onset
1. <u>Lower Back Pain</u>		4.	
2. <u>Upper right leg</u>		5.	
3.		6.	
Allergies <u>None</u>	Height <u>8-6</u>	Weight <u>192</u>	
Significant History (Previous Illness, Surgery, Falls, Accidents) <u>hip replacement</u>			
Current Complaint/ Symptoms <u>Pain and mobility climbing stairs and daily housekeeping</u>			
Prognosis: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Guarded <input type="checkbox"/> Poor			

VITAL SIGNS

Blood Pressure: <input type="checkbox"/> (L) <input checked="" type="checkbox"/> (R) sitting <u>120-80</u> lying _____ standing _____	Temp: <input checked="" type="checkbox"/> r <input type="checkbox"/> a <u>98.6</u>
Pulse: Apical <u>76</u> Radial _____ Rhythm _____	
Resp: <u>80</u> WNL Shallow _____ Labored _____ Other _____	
Lung Sounds: (R) Anterior <u>Good</u> Posterior _____ (L) Anterior _____ Posterior _____	

NUTRITIONAL STATUS

Diet \_\_\_\_\_ Appetite:  Poor  Fair  Good Fluid Restrictions Sodium  
 PO Intake  Adequate  Inadequate Hydration:  Poor  Fair  Good Supplements \_\_\_\_\_  
 Tube feedings  Yes  No Supplier if known (name and phone #) \_\_\_\_\_  
 Who is responsible for feeding? \_\_\_\_\_

PAIN INDEX (Circle)

Location Lower back

Relieved By heating Pad

0 NO HURT 1 HURTS A LITTLE BIT 2 HURTS A LITTLE MORE 3 HURTS EVEN MORE 4 HURTS A WHOLE LOT 5 HURTS WORST

MD CONTACTED:  YES  NO

WHO? DR Blue

SYSTEMS ASSESSMENT CIRCLE OR FILL IN BELOW AS APPROPRIATE

SYSTEM		COMMENTS
Skin	<b>Intact:</b> Pt. at Risk for Breakdown Poor <input checked="" type="checkbox"/> Turgor <input type="checkbox"/> Rash/Itching <input type="checkbox"/> Petechiae <input type="checkbox"/> Cyanosis <input checked="" type="checkbox"/> Ecchymosis <input type="checkbox"/> Lesions <input type="checkbox"/> Pressure <input checked="" type="checkbox"/> Ulcer/Wound Who is responsible for treatment? <u>wife</u>	nothing to report
Mental Status	<input checked="" type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Other _____ Oriented to: <input checked="" type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time <input type="checkbox"/> Impaired Memory <input checked="" type="checkbox"/> Impaired Judgment	needs help
CNS/ Muscular/ Skeletal	<input checked="" type="checkbox"/> Syncope <input type="checkbox"/> Vertigo <input type="checkbox"/> Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Defect in PERRLA <input type="checkbox"/> Numbness <input type="checkbox"/> Hemi paresis <input checked="" type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Decreased ROM <input checked="" type="checkbox"/> Tremors <input type="checkbox"/> Unsteady Gait <input type="checkbox"/> Impaired Balance <input checked="" type="checkbox"/> Weakness <input type="checkbox"/> Pain <input type="checkbox"/> Non-Ambulatory <input type="checkbox"/> Bedbound <input type="checkbox"/> Limited Mobility Uses Device: <input type="checkbox"/> Cane: <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Assist w/Transfers <input checked="" type="checkbox"/> Contact Guard	needs help with mobility may need a walker
Vision	<b>WNL</b> <input checked="" type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Cataracts RT <input type="checkbox"/> LFT <input type="checkbox"/> <input type="checkbox"/> Legally Blind <input type="checkbox"/> Impaired (Can read large print) <input type="checkbox"/> Severely Impaired (Can not read any Print)	None
Hearing	<b>WNL</b> <input checked="" type="checkbox"/> Mildly Impaired Deaf: <input type="checkbox"/> RT <input checked="" type="checkbox"/> LFT Hearing Aid(s)- <input type="checkbox"/> RT <input type="checkbox"/> LFT	check with DR
Oral Motor	<b>WNL</b> Dentures: <input checked="" type="checkbox"/> Full/Partial <input type="checkbox"/> Gum Lesions <input type="checkbox"/> Impaired Chewing <input type="checkbox"/> Impaired Swallowing	Good
Cardiopulmonary	<b>WNL</b> <input checked="" type="checkbox"/> Palpitations <input type="checkbox"/> Dyspnea <input type="checkbox"/> Orthopnea <input type="checkbox"/> Pain <input type="checkbox"/> Cyanosis <input type="checkbox"/> SOB with Min exertion Endurance: <input checked="" type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Cough: <input type="checkbox"/> Non-Productive <input type="checkbox"/> Productive O <sub>2</sub> @ <u>22</u> L/min via _____  Edema: R <u>37</u> cm calf L <u>46</u> cm R <u>64</u> cm ankle L <u>72</u> cm R <u>38</u> cm Instep L <u>43</u> cm  Pedal Pulses: (L) <input checked="" type="checkbox"/> Palpable <input type="checkbox"/> Faint <input type="checkbox"/> Absent (R) <input type="checkbox"/> Palpable <input checked="" type="checkbox"/> Faint <input type="checkbox"/> Absent Color: <input checked="" type="checkbox"/> (L) WNL Abnormal <input type="checkbox"/> (R) WNL Abnormal Pacemaker _____	Should be checked by nurse
Genitourinary	<b>WNL</b> <input checked="" type="checkbox"/> Incontinent <input type="checkbox"/> Pain <input type="checkbox"/> Frequency Urgency <input type="checkbox"/> Burning <input checked="" type="checkbox"/> Catheter: Type <u>A</u> Size <u>5</u> Last Changed? _____ Who is responsible for Catheter? _____	Good
Gastrointestinal	<b>WNL</b> <input checked="" type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Incontinence <input checked="" type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Colostomy Date of last BM <u>5/2/15</u> Action Taken _____ Abdominal: <input checked="" type="checkbox"/> Tenderness <input type="checkbox"/> Distention Bowel Sounds: <input type="checkbox"/> Present <input checked="" type="checkbox"/> Absent	Good
Endocrine	<b>WNL</b> DM Capillary Blood Sugar _____ Patient: IND Dependent w/ Diabetic Mgmt <input type="checkbox"/> Yes <input type="checkbox"/> No Family/patient responsible for F/ S Who _____ Other _____	Good

RN Name/ Title Donald Tuck RN Signature: Donald Tuck Date 5/5/16