ADULT NURSING ASSESSMENT FORM, SIRIRAJ HOSPITAL

WARD .....
H.N. .....
A.N. .....

Personal Data

Name ..... Age .....Sex ..... Education ..... Occupation .....

Admission Date ..... Time .....

Mode of Arrival: ❑ Walk ❑ Wheel Chair ❑ Stretcher ❑ Other .....

Admitted From : ❑ ER Trauma ❑ OPD ❑ Refer ❑ Other.....

Vital signs : Temp. .....°C
HR ..... / min Resp. ..... / min
BP..... mmHg

Height ..... cm
Weight ..... kg

Diagnosis .....

Chief complaint .....

Present Illness .....

.....

.....

Past Illness History .....

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Family Illness History .....

Allergies (Drugs, Food, Other) : ..... Reactions .....

Exercise :	Sleep / Rest : ..... hr/day	Tobacco	Alcohol	Other Drugs/Substances
❑ None	❑ Enough	❑ None	❑ None	❑ None
❑ Always	❑ Not enough	❑ Quit	❑ Quit	❑ Quit .....
❑ Sometimes	What helped in the past?	Smoked duration	Drank duration	Used duration .....
	.....	Quit duration	Quit duration	Quit duration .....
		❑ Continuous	❑ Continuous	❑ Continuous .....
		frequency ...../ day	frequency ...../ day	frequency ...../ day
		duration	duration	duration .....

Information provided by: ❑ Patient ❑ Other .....

Emergency Notify : Name .....

Relationship ..... Phone #.....

Spiritual / Cultural Needs / Emotional Support

Religion .....

Special Religious / Cultural considerations for hospitalization ❑ Yes ❑ No

(If yes, describe .....)

Anxiety : ❑ None ❑ Illness ❑ Finance ❑ Family ❑ Other.....

Support System : ❑ None ❑ Parents ❑ Spouse & Family ❑ Friend(s) ❑ Religious activity ❑ Other .....

Nutrition / Metabolism

❑ Ordinary Diet
❑ Liquid / Soft Diet

Appetite :
❑ Good ❑ Fair ❑ Poor

Special Diet :
❑ DM ❑ Low Na
❑ Low Prot. ❑ High Prot.
❑ Other.....

❑ NPO

Feeding :
❑ Self ❑ Assisted
❑ NG / OG
❑ Gastrostomy/Jejunostomy tube
❑ Parenteral Nutrition

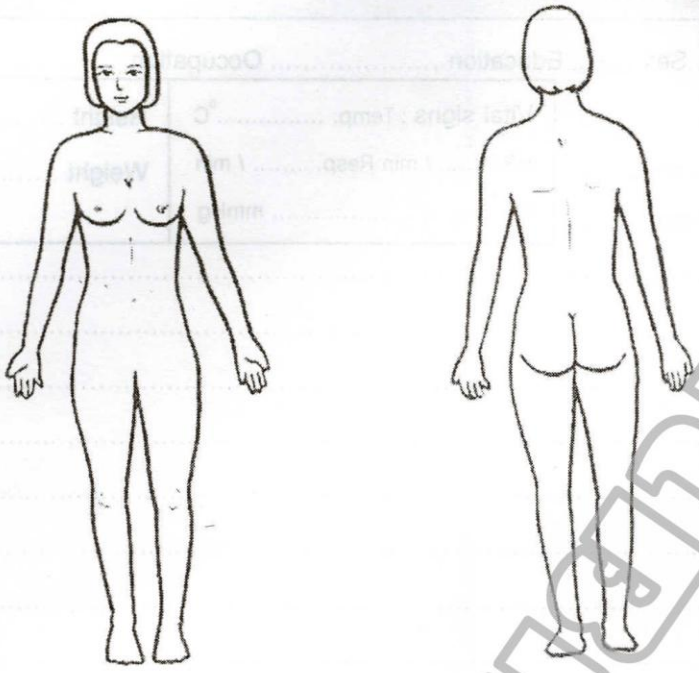
Swallowing Difficulty
❑ None
❑ Solid
❑ Liquid

GI. Problem : ❑ None
❑ Nausea
❑ Vomiting
❑ Other .....

Weight Change : ❑ Unknown ❑ No ❑ Yes
if yes ; ❍ Loss .....kg / ..... wk / mth / yr
❍ Gain .....kg / ..... wk / mth / yr

Skin

Dermal Assessment : ❑ WNL ❑ Abnormal ; Use letter to indicate type and location on diagram



A : Abrasion
B : Burn
C : Contusion
E : Ecchymosis
H : Hematoma
L : Laceration
M : Mass
P : Petechiae
PS : Pressure sore Stage .....
R : Rash
S : Suture
Sc : Scar
SR : Skin reaction from radiation
.....ostomy

Temp. :
❑ Warm
❑ Hot
❑ Cool

Moisture :
❑ Moist
❑ Dry

Turgor : ❑ Good ❑ Poor

Color :
❑ Normal
❑ Pale
❑ Cyanosis
.....
❑ Jaundice

Pressure Ulcer Staging

Stage 1 Persistent redness(in lightly pigmented skin).Persistent red, blue, or purple hues(in dark skin)

Stage 2 Skin loss: abrasion, blister or shallow crater.

Stage 3 Deep crater : not extend down through underlying fascia.

Stage 4 Deep crater : damage to muscle, bone or supporting structures.

Cardiopulmonary

Pulmonary

Rate :
❑ Eupnea
❑ Tachypnea
❑ Bradypnea
❑ Apnea

Rhythm/Depth:
❑ Regular
❑ Irregular
❑ Deep
❑ Shallow

Effort :
❑ Easy
❑ Dyspnea
❑ Orthopnea
❑ Other
.....

Cough :
❑ None
❑ Dry
❑ Productive
❑ Other
.....

Sputum
❑ None
❑ Hemoptysis
❑ Frothy
❑ Color .....
❑ Other .....

Current Treatment :
❑ None
❑ O_2
❑ ETT
❑ Tracheostomy
❑ Ventilator
❑ Chest Tube
❑ Other .....

Cardiovascular

Pulse Rhythm:
❑ Regular
❑ Irregular

Pulse Amplitude:
❑ Strong
❑ Weak .....
❑ Absent .....

Pulse Rate :
❑ Normal
❑ Tachycardia
❑ Bradycardia

Neck Vein Engorged : ❑ No ❑ Yes

Edema :
❑ None
❑ Generalized
❑ Localized.....
❑ Pitting.....

Chest Pain:
❑ No
❑ Yes
Location.....
Refered Pain .....
Duration.....
Frequency .....

ADULT NURSING ASSESSMENT FORM, SIRIRAJ HOSPITAL

NAME ..... H.N. ..... A.N. ..... WARD .....

Neuromuscular

Neurosensory

Level of Consciousness (LOC) :
- ❑ Alert, awake and oriented
- ❑ Lethargic (Sleepy but easily aroused)
- ❑ Stuporus (responsive only to noxious stimuli)
- ❑ Comatose (not responsive to noxious stimuli)

Vision :
- ❑ Normal
- ❑ Impaired
  - ○ Rt .....
  - ○ Lt .....

Device .....

Hearing :
- ❑ Normal
- ❑ Impaired
  - ○ Rt .....
  - ○ Lt .....

Device .....

Speech :
- ❑ Normal
- ❑ Impaired

Device .....

Smell : ❑ Normal ❑ Impaired .....

Sensation :
- ❑ Normal
- ❑ Numbness .....
- ❑ Tingling .....

Musculo-Skeletal

Hahd Grasps :
- ❑ Strong
- ❑ Weak ○ Rt ○ Lt
- ❑ Absent ○ Rt ○ Lt

Joint : ❑ WNL
- ❑ Swollen .....
- ❑ Stiff .....
- ❑ Tender .....
- ❑ Other.....

Weakness :
- ❑ No
- ❑ Yes

.....

Paralysis :
- ❑ No
- ❑ Yes

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Seizure :
- ❑ No
- ❑ Yes

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Movement :
- ❑ Normal
- ❑ Abnormal

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Mobility

Activity / Function :
- ❑ Independent
- ❑ Requires Assistance in
  - ○ Eating ○ Dressing
  - ○ Toileting ○ Bed Mobility
  - ○ Transferring ○ Ambulation
  - ○ Other .....

Prosthetic / Assistive Devices :

(Only require assistive device)
- ❑ Cane
- ❑ Walker
- ❑ Wheel Chair
- ❑ Artificial Limb .....
- ❑ Other .....

Injury: ❑ No
- ❑ Yes .....

.....

.....

Dominant Hand : ❑ Right ❑ Left

Elimination / Reproductive

Gastrointestinal

Oral Cavity :
- ❑ Moist ❑ Dry
- ❑ Abrasion ❑ Tumor
- ❑ Denture
- ❑ Other .....

Abdomen :
- ❑ Soft
- ❑ Tender .....
- ❑ Other .....

.....

Bowel Pattern : ..... time / ..... day

Elimination Problem :
- ❑ None ❑ Constipation
- ❑ Diarrhea ❑ Incontinent
- ❑ Other .....

Genito-Urinary

Bladder :
- ❑ Soft
- ❑ Distended
- ❑ Other

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Voiding : ....(Day,Night)
- ❑ Continent
- ❑ Incontinent
- ❑ Dysuria .....
- ❑ Catheter .....
- ❑ Other.....

Urine :
- ❑ Clear
- ❑ Cloudy
- ❑ Bloody
- ❑ Other.....

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Reproductive

Genital Organ :
- ❑ Normal
- ❑ Abnormal

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.....

Breast :
- ❑ Normal
- ❑ Abnormal

.....

.....

Menstrual Problem :

(Female Only)
- ❑ No
- ❑ Yes .....

.....

LMP : .....

Pain Management

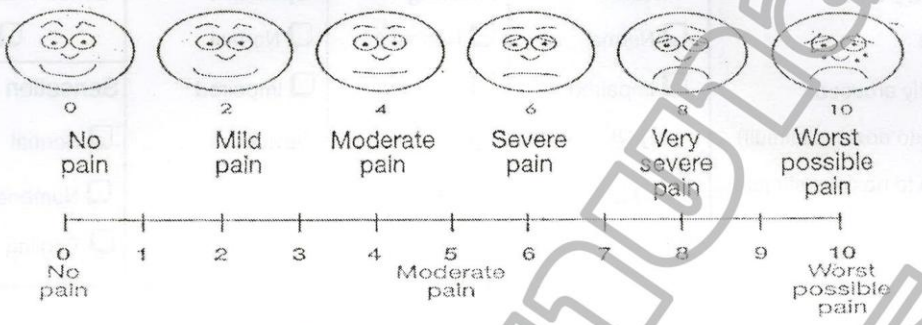
Pain ❑ Yes ❑ No | Pain Location ..... When .....

What causes pain to increase ?.....

Pattern : ❑ Intermittent ❑ Constant ❑ Other .....

How does patient describe the pain : ❑ Burning ❑ Dull ❑ Sharp ❑ Other .....

Intensity :



Does pain affect patient's ability to : ❑ Eat ❑ Activity ❑ Sleep ❑ Elimination ❑ Mood ❑ Self Image ❑ Sexuality ❑ Social Interaction

What relieves pain : ❑ Cold Compression ❑ Hot Compression ❑ Massage ❑ Relaxation ❑ Reposition

❑ Rest / Sleep ❑ Medication..... ❑ Other .....

Information / Teaching / Learning Needs

❑ Orientation ❑ Disease Process ❑ Signs / Symptoms to Report to Med. Staff ❑ Test / Process Treatment

❑ Medication ❑ Pre / Post – Op. Teaching ❑ Infection Control ❑ Wound / Ostomy Care

❑ Self Care ❑ Diet Changes ❑ Activity ❑ Equipment ❑ Safety

❑ Other .....

Discharge Planning Supportive Care

Discharge Screening Criteria

1.Will patient need post discharge assistance with Activity of Daily Living / Physical functioning?

❑ Yes (if yes, complete A&B) ❑ No

A. Does patient have family capable and willing to provide assistance post discharge?

❑ Yes ..... ❑ No

B. Is assistance needed that family can't provide?

❑ Yes ..... ❑ No

2. Are there financial concerns regarding this hospitalization?

❑ Yes ..... ❑ No

Home Environment		Discharge Planning Needs
Lives With:	Lives Where :	❑ Medication .....
❑ Parents/ Family	❑ House	❑ Environment & Economic .....
❑ Spouse	❑ Townhouse	❑ Treatment .....
❑ Friend	❑ Apartment/Condominium	❑ Health .....
❑ Alone	❑ Nursing Home	❑ Outpatient Referral .....
❑ Other	❑ Other	❑ Diet .....

Possible Referral Needs: ❑ Wound Care / Burn Care ❑ Rehabilitation / PT ❑ Speech ❑ OT

❑ Social Service ❑ Psychologist ❑ Other .....

Assessment Initiated by RN : ..... Date ..... Time .....