Nursing Department
General Admission Assessment

AFFIX PATIENT IDENTIFICATION LABEL

Diagnosis:

Arrival Time:_____ **Mode of Arrival:_____** **Admitting From:** □ ER □ OPD □Direct

Allergy/Adverse Reaction……	Body Weight: kg
……	Height: cm
……	

Past Medical History: Obtained From: □ Patient □ Family Member □ Medical Record

□ Other (specify)……...

Past Medical History	Past Surgical History	Previous Hospital Admission

Family History: □ N/A

Heart Disease □	Hypertension □	Diabetes □
□ Stroke	Seizures □	Kidney disease □
Liver disease □	Other_____	

Current Medication ▸ □ None □ Yes ,**If Yes, specify**

(*Key:* **Y** (YES), **N** (NO). *Please strike through if* ***not applicable*** *e.g.* **Y / ~~N~~** .) **IA** (Initial Assessment)

Assessment Data	**Date:** **Time:** **IA**	**Assessment Data**	**Date:** **Time:** **IA**
CARDIOVASCULAR		**SKIN**	
Pulse regular	Y / N	Warm, dry and intact	
Cyanosis	Y / N	T = Turned and repositioned as ordered	
Pallor	Y / N	L = Left B = Back, R =Right,	
Edema	Y / N	**FOOT CARE**	
		D = Diabetic R = routine	
CIRCULATION		**INTRAVENOUS SITE**	
Extremities warm	Y / N	N=No redness, swelling infiltration at site	
Pulses present	Y / N	T=Tubing changed	
Color perfused to all extremities	Y / N	D=Dressing changed	
Sensation present	Y / N	R=Resting [state gauge of IV needle]	
Able to move all extremities	Y / N	RA = Right arm , LA = Left arm	
Toes and fingers	Y / N	RH= Right hand, LH= Left hand	
RESPIRATORY		**RESPIRATORY THERAPY**	
Regular respirations	Y / N	O2 = /min Flow Rate	
Dyspnea	Y / N	Nasal cannula -	
Cough or wheezing	Y / N	Face mask =2	
Lungs clear bilaterally	Y / N	O_2 inhalation	Y / N
GASTROINTESTINAL		**MUSCULOSKELETAL**	
Abdomen soft	Y / N	Full range of motion	Y / N
Tenderness	Y / N	Able to move all extremities	Y / N

Nausea	Y / N		
Vomiting	Y / N		
Constipation or diarrhea	Y / N		
Bowel sounds present	Y / N		
GENITOURINARY		**GENITOURINARY FUNCTION**	
Voiding regularly Sufficient amount	Y / N	FC = Foley	
Urine clear	Y / N	CC = Condom catheter	
Urine colour		Incontinence of Urine	
NEUROLOGICAL STATUS		PC = Peri-care	
Alert and oriented to time, Place and person	Y / N	**WOUND CARE**	
Speech clear	Y / N	Location:	
Responds appropriately to commands	Y / N	Clean = 2 Granulating1=	
Tremors	Y / N	Red / Inflamed = 4 Dry = 3	
Weakness or seizures	Y / N	Dressing dry and intact 5=	
Gait steady	Y / N	Drainage = 6	
		DC= Dressing change	
		S=serous SS=serosanguinous	
		B=Bloody P=Purulent	

PAIN SCREENING

When pain score is more than 0 use the pain assessment form.

FUNCTIONAL SCREENING

- □ Patient cannot position himself in bed
- □ Restricted ROM
- □ Change in Muscle Power
- □ Impaired Daily Living Activities

Any positive response requires assessment by physiotherapist
Referral to physiotherapist □ No need identified □

Occupation: _____

IMPAIRMENT/DISABILITIES

Impaired Hearing □ Dentures □ Impaired vision □ Contacts □
Hearing Aid □ Home O_2 □ Glasses □ _____ Others □

PSYCHOLOGICAL SCREENING

Calm & Cooperative □ Restless □ Depressed □
Agitated □ Confused □ _____ Others □

NUTRITIONAL SCREENING

□	Diabetes Mellitus	□	Needs Therapeutic Diet.	□	Diarrhea > 4days	□	Food Allergy
□	Overweight	□	Psychological Eating Disorder	□	Major Surgery	□	Patient in ICU
□	Under Weight	□	Difficult swallowing / Chewing	□	Hyperemesis gravidarum	□	Tube Feeding
□	Poor Appetite > 3days	□	Unplanned Change in Weight	□	Palliative care		

Any positive response requires nutrition assessment by a dietitian.
Referral to dietician □ No need identified □

SOCIAL SCREENING

1. Marital Status: □ Single □ Married □ Divorced □ Widow

2. Living Alone: □ Lives with _____

3. Number of: Sons ___ Daughters ____

4. Number of: Siblings ____ Female ____ Male _____

5. Care Giver at Home: Domestic Helper □ Female □ Male □ Family Member □ Friend

6. Special Habits: Smoker Y / N Alcohol Abuse Y / N Drug Abuse Y / N

SAFETY

ID Band on □ Yes □ No	Call Bell in Reach □ Yes□ No	Waste Disposal Explained □ Yes □ No
Oriented to Unit □ Yes □ No	Infusion Pump □ Yes □ No	Hand hygiene Explained □ Yes □ No
Others		

Nurse's Name & ID:

Date: **Time:** *(e.g. 1600 H)* **Signature:**