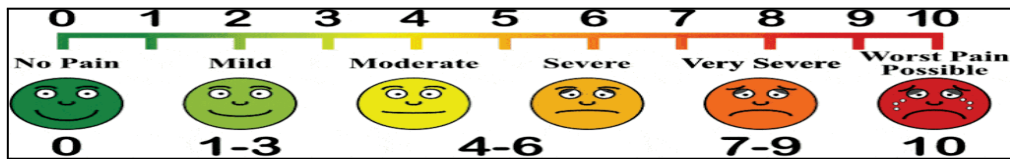


ASSESSMENT OF NURSING - COMMUNICABLE DISEASE

Admission date:

Viral marker:

Receiving date:	Time:	Assessment date:	Time:
On admission patient came by:		Walking	
		Wheel chair	
		Stretcher/cot	
Relative accompanied patient on admission:		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Valuables handed over to the patient family member: Dentures / prosthesis/hearing aid		Object:	
		Received by:	sign:
		Relationship:	contact no.
Major complaints on admission:			
Posted for any procedure: yes <input type="checkbox"/> No <input type="checkbox"/> If yes, specify			
Past history of illness:			
Allergies/any adverse reactions:			
Vital signs	Heart rate:		Temperature:
	Respiration rate:		Spo2:
	Blood pressure:		Pain score:



Functional assessment:				Neurological assessment:			
Bathing: Independent	<input type="checkbox"/>	Dependent	<input type="checkbox"/>	Assisted	<input type="checkbox"/>	GCS score:	
Toileting: Independent	<input type="checkbox"/>	Dependent	<input type="checkbox"/>	Assisted	<input type="checkbox"/>	Level of consciousness:	
Eating: Independent	<input type="checkbox"/>	Dependent	<input type="checkbox"/>	Assisted	<input type="checkbox"/>	4 limb co-ordination:	
Walking: Independent	<input type="checkbox"/>	Dependent	<input type="checkbox"/>	Assisted	<input type="checkbox"/>	Orientation:	

Risk screening:			
Fall risk:	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
Pressure injury:	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
DVT risk:	Yes <input type="checkbox"/>	No	<input type="checkbox"/>

Immunization status:			
COVID-19 vaccination	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
Hepatitis B vaccination	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
Any other vaccination done if applicable			

SEROLOGY:

HIV: HbsAg: HCV:

INFECTION/ PATHOLOGICAL GROWTH:

• viral infections –			
*HIV infection <input type="checkbox"/>	*Cytomegalovirus infection <input type="checkbox"/>	* Varicella zoster virus <input type="checkbox"/>	*Hepatitis B & C <input type="checkbox"/>
• Bacterial infection –			
*Gram- positive bacteria <input type="checkbox"/>	*Gram negative bacteria <input type="checkbox"/>	*Mycobacterium tubercullai <input type="checkbox"/>	psedomonas <input type="checkbox"/>

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KIND OF INFECTION:

Airborne communicable disease:
Contact borne communicable disease:
Blood borne communicable disease:

ISOLATION REQUIREMENT:

Positive pressure isolation
Negative pressure isolation

Socio-economic status and cultural screening:

Marital status	Married <input type="checkbox"/>	Unmarried <input type="checkbox"/>	Single spouse <input type="checkbox"/>
Language <input type="checkbox"/> eaks	<input type="checkbox"/> ad	Write <input type="checkbox"/>
Special habits	Smoking <input type="checkbox"/>	Alcohol abuse <input type="checkbox"/>	Drug abuse <input type="checkbox"/>
Source of income	Pensioner <input type="checkbox"/>	<input type="checkbox"/> ildren	<input type="checkbox"/> other
Specify if any cultural needs to be followed: NA <input type="checkbox"/>			

Safety & Education to patient and family members:

Place Identification band to patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Side rails-up & bed is locked	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Standard precautions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Room orientation given to patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hand hygiene educated by demonstration	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Education on personal hygiene, reduction of cross infection to patient by family members	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Explained about isolation care	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Explained the Patient rights and responsibility	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Information no visiting hours due to immune compromised status	Yes <input type="checkbox"/>	No <input type="checkbox"/>