ADULT HEALTH
STATUS SUMMARY

THIS PAGE TO BE COMPLETED BY NURSE

PRE-SURGICAL SERVICES (SURGICAL SERVICES ONLY)

Date: ________________________ Telephone: ________________________ Visit: ________________________ Vital Signs: ________________________

VITAL SIGNS (OUTPATIENT SURGERY ONLY)

T __________ P __________ R __________ BP(L) __________ BP(R) __________ O2Sat __________ % on __________ Ht __________ Wt __________ lbs/kg/s BMI __________

ADMIT / TRANSFER NOTE

Arrival Date: ________________________ Arrival Time: ________________________ Unit / Room #: ________________________

Arrival From: ________________________

Arrival Mode: ________________________

Walk-in  Strecher  Bed  WC  Carried  Ambulance  Air ambulance  Police  Secure transport

Preferred Language For Discussing Health Care: __________ English  Spanish  Other: ________________________

Why are you here?

Persons under care: ________________________

Emergency services: ________________________

Personal concerns: ________________________

Cultural traditions impacting care? ________________________

SUPPORT (REQUIRED FOR INPATIENT ADMISSIONS ONLY)

Other: ________________________

Meds & Treatment Mgmt: ________________________

Other: ________________________

PERSONAL SAFETY

YES NO

Because violence in the home is a serious risk, we ask everyone

1. Are you here today due to injury or illness related to partner violence?

2. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?

3. Do you feel unsafe in your current relationship?

4. Is there a partner from a previous relationship who is making you feel unsafe now?

NUTRITION SCREENING (REQUIRED FOR INPATIENT ADMISSIONS ONLY)

No identified problem  Unable to assess  Special diet  Supplements  Swallow / aspiration risk

Chewing problems  Wil loss > 13 lb in 1-3 mos.  Poor intake  Nutrition-related illness

FUNCTIONAL STATUS SCREENING (REQUIRED FOR INPATIENT ADMISSIONS ONLY)

Activities of Daily Living: INDEPENDENT  Unable to assess

Unable to assess

Assistant w/ hygiene  Assistant w/ bathing  Assistant w/ toileting  Assistant w/ incontinence  Assistant w/ dressing

Assist w/ cooking  Bath bench  Grab bars  Raised toilet seat  Incontinence pads  Commode

Other:

Mobility: INDEPENDENT  Unable to assess

Unable to assess

Walks w/ cane  Walks w/ walker  Walks w/ crutches  Wheelchair independent

Wheelchair w/ assist  Power Wheelchair  Transfers w/ assist  Stairs w/ assist

Bedbound  Hospital bed  Mechanical lift

Other:

Cognitive: INDEPENDENT  Unable to assess

Unable to assess

Difficulty speaking  Difficulty writing  Difficulty reading  Memory difficulty  TTY/TDD  Communication board

Other:

Meds & Treatment Mgmt: INDEPENDENT  Unable to assess

Unable to assess

Assistant w/ pillbox  Assist w/ syringes  Assist w/ wound care

Assistant w/ Ostomy care  Assist w/ home CAPD  Assist w/ tube drain care  Assist w/ tube feedings

Assistant w/ IV care  Assist w/ trach care

Other:

SUPPORT (REQUIRED FOR INPATIENT ADMISSIONS ONLY)

Cultural traditions impacting care? ________________________

No  Yes  Describe:

Spiritual practices impacting care? ________________________

No  Yes  Describe:

Personal concerns: ________________________

None  Care for others  Overly fearful  Overly anxious  Recent loss

Inadequate support structure  No local support  Other:

Emergency services: ________________________

Able to contact  Unable to contact  Not available

TARGETED REVIEW when current admission < 30 days since last admission

INITIALS: ________________________ SIGNATURE: ________________________ DATE: ________________________
**ADULT HEALTH STATUS SUMMARY**

**INFORMATION SOURCE: PATIENT / RESPONSIBLE PERSON SIGNATURE**

- Patient
- Other / Relationship _____________________________

Signature: _______________________________________

**WHEN DID YOU LAST EAT OR DRINK?**

____________________________________________________

**MEDICAL AND SURGICAL HISTORY**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Have you been in the hospital in the last 30 days? If yes, why? __________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgeries / Procedures / Births (list):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prostheses / Implants (list – for example, Total Joint, AICD, Pacemaker, etc.):</td>
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**ANESTHESIA/TRANSFUSION HISTORY**

- I have had problems with previous ANESTHESIA: ______________
- I have a relative who has had problems with ANESTHESIA: ______________
- Previous blood transfusion? ____________________________
- Transfusion reaction? ____________________________
- I have an objection to blood transfusions: ________________
  - Religious objection
  - Personal objection

**SUBSTANCE USE**

<table>
<thead>
<tr>
<th>Tobacco use in last 12 months</th>
<th>Uses</th>
<th>How Much / Often?</th>
<th>Date Last Use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quit Date</td>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Alcohol</th>
<th>Marijuana</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>IV Substance</td>
<td>Other</td>
</tr>
</tbody>
</table>

**ADDITIONAL NARRATIVE NOTES**

<table>
<thead>
<tr>
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**DISCHARGE PLANNING (OUT-PATIENT SETTINGS)**

**Discharge Transportation Provider:**

- Same as Contact Person (page 1)
- Needs to be called when patient is ready to go home
- Is planning to return at: ___________________ (time)

**Other History:**

____________________________________________________

**INFORMATION SOURCE: PATIENT / RESPONSIBLE PERSON SIGNATURE**

- Patient
- Other / Relationship _____________________________

Signature: _______________________________________

**DATE/TIME**

- Initials
- Staff signature/title
**ADULT HEALTH STATUS SUMMARY**

**INFORMATION SOURCE: PATIENT / RESPONSIBLE PERSON SIGNATURE**

- Q Patient
- Q Other / Relationship 

Signature: ________________________________

**WHEN DID YOU LAST EAT OR DRINK?**

Signature: ________________________________

**MEDICAL AND SURGICAL HISTORY**

- Q Have you been in the hospital in the last 30 days? If yes, why? ________________________________

- Q Surgeries / Procedures / Births (list): ________________________________

- Q Prostheses / Implants (list – for example, Total Joint, AICD, Pacemaker, etc.): ________________________________

**ANESTHESIA/TRANSFUSION HISTORY**

- Q I have had problems with previous ANESTHESIA: Muscle weakness

- Q I have a relative who has had problems with ANESTHESIA: Muscle weakness

- Q Previous blood transfusion?

- Q Transfusion reaction?

- Q I have an objection to blood transfusions: Religious objection

**SUBSTANCE USE**

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<tr>
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<th>Date Last Use?</th>
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<tr>
<td>Tobacco use in last 12 months</td>
<td>Quit Date</td>
<td>Meth / Amphetamines</td>
<td>Quit Date</td>
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<tr>
<td>Alcohol</td>
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**ADDITIONAL NARRATIVE NOTES**

**DISCHARGE PLANNING (OUT-PATIENT SETTINGS)**

Discharge Transportation Provider:

- Q Same as Contact Person (page 1)
- Q Will remain here at the hospital

Needs to be called when patient is ready to go home

Is planning to return at: ________________________________

Name: ________________________________

Phone #1: ________________________________ Phone #2: ________________________________

**INFORMATION SOURCE: PATIENT / RESPONSIBLE PERSON SIGNATURE**

- Q Patient
- Q Other / Relationship 

Signature: ________________________________

**INFORMATION SOURCE: PATIENT / RESPONSIBLE PERSON SIGNATURE**

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- Q Other / Relationship 

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- Q Patient
- Q Other / Relationship 

Signature: ________________________________

**INFORMATION SOURCE: PATIENT / RESPONSIBLE PERSON SIGNATURE**

- Q Patient

Signature: ________________________________