**NURSING ASSESSMENT**

Date: _____ / _____ / _______  Unit Arrival Time: _____:____ AM □ PM □ Unit: _______

Legal Status: ___________________  Referral Source: ___________________

How Admitted: □ Ambulatory □ Ambulance □ Wheelchair □ Stretcher

Nourishment Offered □ Yes □ No  Content: ____________________________

A Psychiatric Technician may complete remainder of page

<table>
<thead>
<tr>
<th>Contraband</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drugs/Medication</strong></td>
</tr>
<tr>
<td><strong>Money</strong></td>
</tr>
<tr>
<td><strong>Matches/Lighters</strong></td>
</tr>
<tr>
<td><strong>Valuables</strong></td>
</tr>
<tr>
<td><strong>Sharps</strong></td>
</tr>
<tr>
<td><strong>Item(s) Found/Other</strong></td>
</tr>
<tr>
<td><strong>Glass</strong></td>
</tr>
</tbody>
</table>

*Notify Supervisor of any contraband items found*

Supervisor Notified □ Yes □ No  Date: _____ / _____ / ____  Time: _____:____ AM □ PM

Items Placed in: _____________________________  by: _____________________________

Items Transferred to: _____________________________  by: _____________________________

Search Completed by: _____________________________  Signature/Title  Witness: To Search  Signature/Title

<table>
<thead>
<tr>
<th>Unit Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Room Assigned</strong></td>
</tr>
<tr>
<td><strong>Hygiene Times</strong></td>
</tr>
<tr>
<td><strong>Operation of Shower</strong></td>
</tr>
<tr>
<td><strong>Awake/Bed Times</strong></td>
</tr>
<tr>
<td><strong>Telephone Usage</strong></td>
</tr>
<tr>
<td><strong>Operation of Wash/Dryer</strong></td>
</tr>
<tr>
<td><strong>Meal Times</strong></td>
</tr>
<tr>
<td><strong>Visitation</strong></td>
</tr>
<tr>
<td><strong>Lab Work/Vital Signs</strong></td>
</tr>
<tr>
<td><strong>Medication Times</strong></td>
</tr>
<tr>
<td><strong>Unit Rules</strong></td>
</tr>
<tr>
<td><strong>Problems (Who to Notify)</strong></td>
</tr>
<tr>
<td><strong>PSR/Unit Groups</strong></td>
</tr>
<tr>
<td><strong>Least Restrictive Measures</strong></td>
</tr>
</tbody>
</table>

Date: _____ / _____ / _______  Time: _____:____ AM □ PM

Staff Signature/Title  Printed Name

Date: _____ / _____ / _______  Time: _____:____ AM □ PM

RN Initiating Assessment  Signature/Title  Printed Name

Memphis Mental Health Institute  Addressograph

Nursing Assessment
### Medical History

<table>
<thead>
<tr>
<th>Medical Problem</th>
<th>Yes</th>
<th>No</th>
<th>Medical Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
<td>Fainting/Dizzy Spells</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hypertension</td>
<td>☐</td>
<td>☐</td>
<td>Kidney/GU Problems</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart Problems</td>
<td>☐</td>
<td>☐</td>
<td>Vomiting</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Respiratory</td>
<td>☐</td>
<td>☐</td>
<td>Nausea</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Seizures</td>
<td>☐</td>
<td>☐</td>
<td>Sex. Transmitted Diseases</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Liver Problems</td>
<td>☐</td>
<td>☐</td>
<td>Gynecological Problems</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Last Menstrual Cycle**

Date: / / 

**Pregnancies**

Gravida

Para

Denies Significant History

Other:

---

**Known Medical Problems (Please describe Current Status of medical Problems marked “Yes”)**

---

### Allergies

<table>
<thead>
<tr>
<th>Substance</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Latex</td>
<td></td>
</tr>
<tr>
<td>Food:</td>
<td></td>
</tr>
<tr>
<td>Meds:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

### Devices

- Eyeglasses
- Hearing Aid
- Dentures
- Walker
- Wheelchair
- Ostomy
- Pace Maker
- Infusion Line
- Other:

### Vital Signs

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Right Arm</th>
<th>Left Arm</th>
<th>Thigh</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pulse</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Respiration</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Temperature</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- Regular
- Deep
- Shallow
- Other:
- Deep
- Quiet
- Labored
- Oral
- Axillary
- Anal
- Tympanic

### Current Medications Prescribed and OTC Meds (Over The Counter)

<table>
<thead>
<tr>
<th>Medication/</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Date/Time of last Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Addressograph
## Gastrointestinal (GI)/Genitourinary (GU)

<table>
<thead>
<tr>
<th>GI</th>
<th>Yes</th>
<th>No</th>
<th>GU</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Pattern</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloody Stools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigestion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Bowel Movement:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nocturia</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Enuresis</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Polyuria</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dysuria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematuria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder Distention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## RESTORATIVE

<table>
<thead>
<tr>
<th>Difficulty Falling Asleep</th>
<th>Yes</th>
<th>No</th>
<th>Normal Hours of Sleep:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hours of Sleep Per Night:</td>
<td></td>
</tr>
<tr>
<td>Difficulty Staying Asleep</td>
<td></td>
<td></td>
<td>Are there Factors Affecting Your Sleep Pattern?</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Morning Awakening (EMA)</td>
<td></td>
<td></td>
<td>Describe:</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## AFFILIATIVE

Manner of relating and communicating, development of relationships, quality and duration of relationships

- Cooperative □  Good eye contact □  Withdrawn □  Distrustful □  Prefers to be alone □
- Passive □  Avoids eye contact □  Manipulative □  Intrusive □  Difficulty interacting w/others

Religion:             Does he/she speak English? □ Yes □ No  Language:  

How does he/she learn best? 

How does he/she best communicate? 

Comments:  

Addressograph
Use key below to identify patient’s level of ADL functioning for each item (Self Care Data)

<table>
<thead>
<tr>
<th>Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Independent</td>
</tr>
<tr>
<td>S</td>
<td>Supervision</td>
</tr>
<tr>
<td>D</td>
<td>Direct Assistance</td>
</tr>
<tr>
<td>VP</td>
<td>Verbal Prompting</td>
</tr>
<tr>
<td>PA</td>
<td>Physical Assistance</td>
</tr>
<tr>
<td>AD</td>
<td>Assistive device</td>
</tr>
<tr>
<td>R</td>
<td>Refuses</td>
</tr>
<tr>
<td>N/A</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

- Eating
- Grooming
- Dressing/Undressing
- Menstrual Care
- Brushing Teeth
- Bathing
- Bed Making
- Communicate Needs
- Shaving
- Toileting
- Care of Clothing
- Other:

FUNCTIONAL SCREENING

Check, if Impaired, and Notify Attending Physician

- Speech
- Hearing
- Coordination/Balance
- Swallowing (See Dysphagia Screening)

Date of Attending Physician Notification / / Time of Notification : AM PM

FALL RISK ASSESSMENT

If “Yes” response, indicate point score.

1. Age
   - If 65 or over = 2 points  19-64 = 0 points
   - Yes (2 points)  No  Unkn

2. Fall History
   - Have you fallen in the last 6 months
   - Yes (3 points)  No  Unkn
   - Have you been hospitalized for fall in last 6 months
   - Yes (3 points)  No  Unkn

3. Mobility
   - Do you have problems walking?
   - Yes (4 points)  No
   - Unsteady Gait
   - Use Assistive Device
   - Loss of Limb

4. Nutrition
   - Do you have problems with nutrition?
   - Yes (2 points)  No
   - Dehydration
   - Malnutrition
   - Poor Skin Turgor

5. Elimination
   - 2 points, if yes
   - Yes (2 points)  No

6. Current Medications
   - Take medications that make you dizzy?
   - Yes (2 points)  No
   - Narcotics
   - Sedatives
   - Tranquilizer
   - Hypnotics
   - Antipsychotics
   - Multiple Medications

7. Medical History
   - Do you have any history of:
     - Parkinson’s
     - Diabetes
     - Hearing Problems
     - Seizures
     - Neurological D/O
   - Yes (2 points)  No

8. Mentation
   - Do you have problems with your memory?
   - Yes (2 points)  No
   - Confused
   - Dementia
   - Alzheimer’s
   - Acutely Psychotic

9. Sensory Deficits
   - 2 points
   - Blind
   - Hard of Hearing
   - Poor Vision
   - Yes (2 points)  No
   - Deaf
   - Diabetic Neuropathy

Rating Instructions: ≥ 8 total score indicates a greater risk for falls, initiate fall precautions

Nursing Staff shall initiate the following precautions:

- 15 min Special Observations
- Flag Chart
- Notify the Physician
- Write Nursing Interventions
- Place purple armband on patient
- Review Falls Education Pamphlet with Patient

Addressograph
Are you in pain?  ☐ Yes  Location: ___________________  ☐ No  If no, assessment is complete.

If yes:  
1. Rate pain intensity using Wong Baker or FLACC Scale (use of only one scale required)
2. Complete Pain Assessment Flow Record

Use Wong Baker Scale for patients that can self-report pain.

Use FLACC Scale for patients that are unable to report pain. Intensity Level, 0-10

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant quivering chin, clenched jaw</td>
<td></td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking or legs drawn upward</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
<td>Squirming, shifting back and forth, tense</td>
<td>Arched, ridged, or jerking</td>
<td></td>
</tr>
<tr>
<td>Cry</td>
<td>No crying (awake or asleep)</td>
<td>Moans or whimpers, occasional complaint</td>
<td>Crying steadily, screams or sobs, frequent complaints</td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging, or being talked to, distractible</td>
<td>Difficult to console or comfort</td>
<td></td>
</tr>
</tbody>
</table>

Total Score: ______

INITIAL DYSPHAGIA SCREENING (MAY HAVE DIFFICULTY SWALLOWING)

☐ Loss of Dentition  ☐ Regurgitation through nose mouth, tracheotomy tube
☐ Improper Denture fit  ☐ Gurgly (wet) voice after eating/drinking
☐ > 80 yrs. old  ☐ Mealtime assistance-clenching teeth, pushing food away or clenching throat
☐ Tongue Thrusting/Poor Control  ☐ Alzheimer’s /Dementia
☐ Facial Weakness  ☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Excessive Secretions  ☐ Closed Head Injury
☐ Decrease Saliva  ☐ Myotonic Dystonia
☐ Multiple Sclerosis  ☐ Parkinson’s Disease
☐ Muscular Dystrophy  ☐ Poliomyelitis
☐ Myasthenia Gravis  ☐ Stroke/CVA
☐ Cystic Fibrosis  ☐ Torticollis
☐ Cerebral Palsy  ☐ Guillain-Barre Syndrome
☐ Slurred Speech  ☐ Inflammation of the Pharynx or Esophagus
☐ Horse, harsh or breathy voice  ☐ Throat Webs
☐ Excessive tongue movement  ☐ History of Aspiration or Pneumonia
☐  ☐ History of Nonspecific Respiratory Problems

Complete Dysphagia Screening Form, if any of the above criteria is met.

Addressograph
Indicate site of assessment findings on the diagram below and Skin assessment chart.

**Skin Assessment Chart**

<table>
<thead>
<tr>
<th>Problems/Issues</th>
<th>Description-size, color, elevations, drainage, texture, symmetry etc</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Problems Noted</td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
</tr>
<tr>
<td>Lacerations</td>
<td></td>
</tr>
<tr>
<td>Ulcer (stage 1-4)</td>
<td></td>
</tr>
<tr>
<td>Scars</td>
<td></td>
</tr>
<tr>
<td>Bruises</td>
<td></td>
</tr>
<tr>
<td>Burns (1º to 4º)</td>
<td></td>
</tr>
<tr>
<td>Sores</td>
<td></td>
</tr>
<tr>
<td>Abrasions</td>
<td></td>
</tr>
<tr>
<td>Scars</td>
<td></td>
</tr>
<tr>
<td>Moles</td>
<td></td>
</tr>
<tr>
<td>Edema (0 to +4)</td>
<td></td>
</tr>
<tr>
<td>Color Change</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td></td>
</tr>
<tr>
<td>Acne</td>
<td></td>
</tr>
<tr>
<td>Itching (pruritus)</td>
<td></td>
</tr>
<tr>
<td>Healing Problems</td>
<td></td>
</tr>
<tr>
<td>Risk For Breakdown</td>
<td></td>
</tr>
<tr>
<td>Tumor</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

**Color**

- □ WNL
- □ Pale
- □ Mottled
- □ Cyanotic
- □ Jaundiced

**Temperature**

- □ WNL
- □ Hot
- □ Cool
- □ Cold

**Turgor/Texture**

- □ WNL
- □ Poor
- □ Dry
- □ Rough

Comments: _____________________________________________
________________________________________________________
________________________________________________________

**Braden Scale**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensory Perception</strong></td>
<td>Completely limited</td>
<td>Very limited</td>
<td>Slightly limited</td>
<td>No Impairment</td>
<td></td>
</tr>
<tr>
<td><strong>Moisture</strong></td>
<td>Constantly moist</td>
<td>Moist</td>
<td>Occasionally moist</td>
<td>Rarely moist</td>
<td></td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>Bedfast</td>
<td>Chair fast</td>
<td>Walks occasionally</td>
<td>Walks frequently</td>
<td></td>
</tr>
<tr>
<td><strong>Mobility</strong></td>
<td>Completely Immobile</td>
<td>Very limited</td>
<td>Slightly limited</td>
<td>No limitations</td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td>Very Poor</td>
<td>Probably inadequate</td>
<td>Adequate</td>
<td>Excellent</td>
<td></td>
</tr>
<tr>
<td><strong>Friction and Sheer</strong></td>
<td>Problem</td>
<td>Potential problem</td>
<td>No apparent problem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Low Risk 15-18
Moderate Risk 13-14
High Risk ≤ 10-12
Severe Risk ≤ 9

Total Score: _____

Addressograph
## Orientation

<table>
<thead>
<tr>
<th>Person</th>
<th>Place</th>
<th>Time</th>
<th>Situation</th>
<th>None</th>
</tr>
</thead>
</table>

## Thought Process

- Loose Association
- Delusional
- Blocking
- Self-Harm
- Hopelessness
- Suicidal
- Persecutory
- Cognitive Impairment
- Grandiose
- Homicidal
- Helplessness
- No Problems Assessed
- Flight of Ideas
- Ideas of Reference
- Obsessive

Use Patient’s Quotes, Assessments, and Outside Information (indicate source) to Describe Items Checked Above

## Hallucinations

- Command
- Visual
- Auditory
- No Problems Assessed
- Olfactory
- Kinesthetic
- Gustatory

Use Patient’s Quotes, Assessments, and Outside Information (indicate source) to Describe Items Checked Above

## Affect

- Alert
- Labile
- Appropriate
- Angry
- Flat
- Other: __________
- Blunted

Describe: __________

## Speech

- Normal
- Slurred
- Slowed
- Loud
- Pressured
- Mute
- Other: __________

## Mood

Rate Mood 1-10 (Low to High)

- Depressed
- Rating: ______
- Irritable
- Rating: ______
- Despondent
- Rating: ______
- Euphoric
- Rating: ______
- Manic
- Rating: ______
- Other:
- Rating ______
- Sad
- Rating: ______
- Euthymic
- Rating: ______

Describe: __________

## Behavior/Judgment

- Cooperative
- Compulsive
- Assertive
- Protects self
- Uncooperative
- Self-Harm
- Avoidant
- Over Acts
- Passive
- Suicidal
- Poor Judgment
- Harm to Others
- Aggressive
- Can report incidents
- Good Judgment
- Other: __________

Use Patient’s Quotes, Assessments, and Outside Information (indicate source) to Describe Items Checked Above

Addressograph
Protection of self from perceived harm, suicidality, homicidality, and self destructive behavior

- **Aggressive Behavior**
  - Describe: 
  - Follow-up: 

- **Threatening Behavior**
  - Describe: 
  - Follow-up: 

- **Homicidal Behavior**
  - Describe: 
  - Follow-up: 

- **Suicidal Behavior**
  - Describe: 
  - Follow-up: 

- **Self-Injurious**
  - Describe: 
  - Follow-up: 

- **Previous Suicide Attempts**
- **Engages in intense frequent Acting Out**
- **Elopement Risk**
- **Sexual Acting Out**
- **Lacks Awareness of Cause and Effect**
- **Fire Setting**
- **Compulsive Behavior**
- **Inappropriate Response to real or perceived threat**
- **Poor Impulse Control**
- **Lacks Awareness of potentially hazardous situations**

What has worked in the past with managing your anger?

- **Being Touched**
- **Not Being Touched**
- **Other:** 
- **Being Alone**
- **Being With Others**
- **Reading**
- **Warm Shower**
- **Warm Bath**
- **Listening to Music**
## EVIDENCE OF ABUSE / NEGLECT

### Scratches, cuts, bruises, or burns
- [ ] No
- [ ] Yes
- If yes, please describe:

### Welts, scalp injury, or gag marks
- [ ] No
- [ ] Yes
- If yes, please describe:

### Sprains, punctures, broken bones
- [ ] No
- [ ] Yes
- If yes, please describe:

### Signs of confinement or sexual abuse/rape
- [ ] No
- [ ] Yes
- If yes, please describe:

### Malnourishment and/or dehydration
- [ ] No
- [ ] Yes
- If yes, please describe:

### Over or under-medicated
- [ ] No
- [ ] Yes
- If yes, please describe:

### Lack of heat, running water, or electricity
- [ ] No
- [ ] Yes
- If yes, please describe:

### Lack of personal hygiene or clean clothing
- [ ] No
- [ ] Yes
- If yes, please describe:

**Follow Up:** If any “Yes” responses raise suspicion of abuse/neglect, refer to Social Worker. After hours notify Social Services Secretary.

Date of Social Worker/Secretary Notification: / / 
Time of Notification: : [ ] AM [ ] PM

## SUBSTANCE USE HISTORY

<table>
<thead>
<tr>
<th>Substance</th>
<th>Type</th>
<th>Current Pattern Amt. Used</th>
<th>Date/Time of Last Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine/Crack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever been in treatment for drug related issues?
- [ ] Yes Describe: 
- [ ] No

Was the treatment successful?
- [ ] Yes Describe: 
- [ ] No

### Indications of Substance Abuse
- [ ] Recurrent substance use resulting in failures at work, school or home
- [ ] Recurrent substance use in situations that are hazardous, e.g. DWI
- [ ] Recurrent substance-relate legal problems
- [ ] Continued substance use despite having persistent or recurrent social or interpersonal problems
- 1 or more checked criterion for **Substance Abuse** indicates a maladaptive pattern

### Indications of Substance Dependence
- [ ] Tolerance: need for ↑ amount of substance for same effect or diminished effect with same amount
- [ ] Withdrawal or substance taken so as to avoid withdrawal e.g. “eye-opener” in AM
- [ ] Substance taken in ↑ amounts over longer period of time
- [ ] Persistent desire or unsuccessful effort to cut down or control use
- [ ] Great deal of time spent to obtain the substance
- [ ] Social, work, or recreational activities given up r/t substance use
- [ ] Use continues despite recurrent physical/psychological problems r/t use e.g. depression, liver disease
- 3 or more checked criterion for **Substance Dependence** indicates a maladaptive pattern

Check one: [ ] Abuse [ ] Dependence [ ] No Clear Evidence

Addressograph
Past hospitalization (How many, when, and where?): ____________________________________________

What is the longest length of time the patient has been out of the hospital? _________________________

Description Data: Age/ Race: _______________ Diagnosis: ____________________________

Patient reason for admission: ______________________________________________________________

Documented reason for admission: ___________________________________________________________

Observation of Behavior: _________________________________________________________________

Observation of Appearance :

Hair: ☐ Kempt ☐ Unkempt

Hygiene: ☐ No Odor ☐ Odorous

Clothing: ☐ Clean ☐ Unclean

☐ Weather appropriate ☐ Not Weather Appropriate

☐ Bizarre dress Describe: _________________________________________________________________

Additional Comments: ___________________________________________________________________

Focus of hospitalization (Problem/Psychiatric Substance Abuse Symptoms which necessitated inpatient hospitalization). Please list findings from Nursing Assessment Data and integrated findings into the Initial Treatment Plan.

_____________________________________________________________________________________

Physical/Medical problems present that will/may require continued treatment/nursing care during this hospitalization( p. 8)

_____________________________________________________________________________________

Potential risk factors (behavior/emergency, nutritional, potential fall, elopement, etc….) ________________________

_____________________________________________________________________________________

Potential recidivism issues (housing, financial, lack of supportive relationship, etc…) _________________________

_____________________________________________________________________________________

Remember to address areas within the scope and standards of psychiatric/mental health nursing practice in the ITP such as self-care activities, milieu therapy, health teaching, medication teaching, counseling, crisis care, health promotion, etc… (see ITP)

_____________________________________________________________________________________

RN Completing Assess. Signature/Title __________________________ Printed Name ____________________________

Date: _____ / _____ / _____ Time: _______ ☐ AM ☐ PM
INGESTIVE

BMI >30(Obese)  
AIDs  
Type 1/Type 2 Diabetes Mellitus  
HIV+  
H/O Cardiovascular Disease  
H/O GERD  
H/O Alcohol/Substance Abuse  
H/O Dysphagia (See Initial Dysphagia Screening)  
Current chemo/radiation therapy  
Active Diverticular Disease  
Decubitus Ulcers  
Active kidney/liver disease  
> 5lbs weight loss in last week  
BMI < 20 (Underweight)  
Appetite:  
Good  
Fair  
Poor  
Recent Changes  
If unable to obtain height/weight, patient appears:  
Underweight  
Normal weight  
Overweight  

Date of dietary referral:  

Time of dietary referral:  
AM  
PM

Addressograph