ADMISSION HISTORY
Adult 18 years and older

McAllister, Dorel
DOB 01/02/1939
123 456 789

Physician Diagnosis SBO

Reason for Visit surgery

Primary Language: ☑ English ☐ Other language *(specify)*: _____ Understands English: ☑ Yes ☐ No
☐ Unable to express self Interpreter needed: ☐ Yes ☐ No Interpreter Contact information: _____

Source of information: Patient

☐ Allergy/ADR form completed/updated

VITAL SIGNS

Height	Weight	Temp	Pulse/Apex	Respiratory Rate	Pulse Oximetry	BP
150 ☑ cm ☐ in	68 ☑ kg ☐ lb	36°	68	16	94 %	140/68
Method A	Method A	Route PO			Oxygen *(specify)* RA	

→ **Method key:** **A** = Actual **E** = Estimated **R** = Reported

ARO SCREENING **Complete within 24 hours of Admission**

☐ See ARO screening form (#807910)

1. Has the patient ever had an ARO? ☐ Yes ☑ No ☐ MRSA* ☐ CPO**
2. Has the patient had an overnight stay in a hospital or undergone a medical/surgical procedure **outside Canada** within the past 12 months? ☐ Yes ☑ No
3. Has the patient had hemodialysis **outside Canada** within the past 12 months? ☐ Yes ☑ No
4. Has the patient had close contact*** with a known CPO patient within the past 12 months? ☐ Yes ☑ No/unknown
5. Has the patient been transferred from a facility with known, active CPO transmission? ☐ Yes ☑ No/unknown

* MRSA: Methicillin-Resistant Staph Aureus
** CPO: Carbapenemase-producing organisms
*** Close contact is defined as: household member, roommate in hospital

If question 1 is "Yes" for CPO or "Yes" answer to any of questions 2, 3, 4, 5, implement Contact Precautions and swab for CPO

Requisition Screening for CPO:
- Rectal swab (must have fecal staining) ☐ Swab done by _____
- Stool if rectal swab not available

If questions 1-5 are "No", continue on with question 6.
6. Has the patient been hospitalized for more than 48 hours within the last 3 months?
   ☐ No – No further action
   ☐ Yes – Swab for MRSA – if patient has large draining wounds and/or diarrhea, **Implement Contact Precautions**

Requisition Screening for MRSA:
1. Nose (1 swab both nares) ☐ Swab done by _____
2. Groin (1 swab both sides) ☐ Swab done by _____
3. One of any open wound ☐ Swab done by _____

AGGRESSIVE BEHAVIOR SCREENING ☑ Not Applicable

✓ Consider for Plan of Care

☐ History of Violence ☐ Physically Aggressive ☐ Verbally Aggressive *Complete the **Aggressive Behavior Assessment Scale – Acute Care # 826155** from the Aggressive Behavior Toolkit on the Violence Prevention Program Insidenet*

TOBACCO DEPENDENCE

Have you used tobacco in the last 6 months? ☐ Yes ☑ No Are you interested in quitting? ☐ Yes ☐ No
If Yes, provide patient with: *Quit Now – Dial 811/quitnow.ca*
Would you like help in managing withdrawal symptoms? ☐ Yes ☐ No
*Contact Physician about **Nicotine Replacement Therapy PPO # 829435***

SUBSTANCE USE

Do you drink alcohol? ☑ Yes ☐ No How much do you drink? 2 glasses wine daily
Have you ever had symptoms of withdrawal? ☐ Yes ☑ No When was your last drink? _____
Do you use recreational drugs? ☑ Yes ☐ No
What drugs do you use? Marijuana When was your last use? 1 week ago

Date	Time	Initials
May XX	1420	

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PRE-HOSPITAL LEVEL OF FUNCTION: 48/6 Screening and ADLs	✓Consider for Plan of Care	Date / Initials
Source of information:		
FUNCTIONAL MOBILITY (How well you move about) 1. Have you had a slip, trip or fall in the last 6 months? ☐ Yes ☑ No 2. Do you limit your activities because you are afraid of falling? ☐ Yes ☑ No Comments:		
Do you need help: Toileting ☐ Yes ☑ No; Getting out of bed ☐ Yes ☑ No Getting dressed ☐ Yes ☑ No; Getting around in your home ☐ Yes ☑ No Bathing/showering ☐ Yes ☑ No; Climbing stairs ☐ Yes ☑ No Do you use mobility aids? ☐ Yes ☑ No ☐ Cane ☐ Walker ☐ Wheelchair ☐ Immobile ☐ Mechanical Lift Do you have: ☐ Brace ☐ Splint ☐ Foot Orthotics ☐ Compression Stockings Specify Comments:		
PAIN MANAGEMENT 1. Do you take medications or do other things to lessen or prevent pain? ☑ Yes ☐ No If yes, what? Percocet 2. Have you had any pain in the last 2 weeks? ☑ Yes ☐ No Comments: Abd.		
Acute Pain *(specify)* Abd. accompanied c abd. distention + constipation Chronic Pain *(specify)* Comments:		
MEDICATION MANAGEMENT 1. Do you think medications may have contributed to this hospital visit? ☐ Yes ☑ No 2. Do you take your medications differently than the doctor ordered? ☐ Yes ☑ No Comments:		
Best Possible Medication History completed? ☐ Yes ☑ No Did you bring your own medications to hospital? ☐ Yes ☑ No Do you need help taking your medication? ☐ Yes ☐ No Medication aids used at home *(specify)* Comments:		
NUTRITION/SWALLOWING 1. Do you have trouble swallowing or do you cough or choke when eating or drinking? ☐ Yes ☑ No 2. Have you lost weight recently without trying? ☐ Yes ☑ No 3. Do you have any special food or dietary needs? ☐ Yes ☑ No Comments:		
Diet/Fluid types Bland, High Fibre List special foods/dietary needs Ability to self feed ☑ Yes ☐ No Assistance required *(specify)* Dentures ☑ Full ☐ Upper ☐ Lower Comments:		