INTEGRITY HOME HEALTH CARE SERVICES ADMISSION CHECKLIST

PATIENT NAME: _____ **TYPE OF VISIT:** _____ **DATE & TIME OF VISIT:** _____

DOB: SS#:

Any other agency providing services to you?

If yes, name/phone/svcs provided:

Religion:

Flu Vaccine: Y / N, When?

Pneumo Vax: Y / N, When?

Shingles Vax: Y / N, When?

Allergies/Reaction:

Ht: , Wt:

Pharmacy:

Pharm Phone:

Vital Signs

Parameters:

TEMP: >101.6
PULSE: >100 OR <60
RESPIRATIONS: >30 OR <14
SYSTOLIC BP: >160 OR <90
DIASTOLIC BP: >90 OR <60
O2 SAT: <90%
FASTING/RANDOM BLD SUGAR: >300 OR <60
WEIGHT (CHF PATIENTS):
Gain OF >2 lbs/2 days or >5 lbs /1 wk

Pulse –

Reg / Irreg / Strong / Weak

Temp –

Oral / Rectal / Axilla / Tymp / Temp

Resp – O2 Sat -

Lung Sounds:

O2? ___ L via NC, Mask, Trach

BP –

L / R / Sitting / Standing / Lying

Pain (take note of pain med)

Location:

Date of Onset:

Current level:

Description:

Pain level post-med:

Cardiovascular

Edema:

Nonpitting / Pitting: 1+, 2+, 3+, 4+

If CHF, check Wt now:

Then instruct daily weights check

Other:

GI

Eating ok?

Swallowing issues?

Tube Feed?

Type of tube:

Feed/Dose/Freq:

Last BM: BM Freq:

Colostomy?

Voiding ok?

Foley/Supra, Last changed?

Foley size: ____ Fr, ____ ml balloon

Incontinence: Bowel / Urine

Recent UTI, when:

Dialysis? If yes, where?

Schedule? MWF or TThS

Dialysis Time start:

Mental Status

Dementia: Y / N

Depression: Y / N

MSW Needed?

EENT

Glasses?

HOH, Hearing Aid? L / R

Dentures? Uppers / Lowers

Endocrine

BS level and when taken:

How often and by Whom:

If on insulin, when started?

ADL/Mobility – Think Safety!

TUG Score:

Bathing: I / RA / D

History of Falls: Y / N

If recent fall, when?

Dressing: I / RA / D

Gait Instability: Y / N

PT Need: Y / N

OT Need: Y / N

IV Infusion

Type of Line:

# of Lumens:

Location:

ECL (Ext Cath Length):

Baseline Arm Circum if PICC:

Last dsg change:

DME/Supplies

List all DME already have:

List DME's needed and why:

Emergency Contact

Name:

Relationship:

Phone:

Living will? Y / N

POA:

Full code / DNR

Living Arrangements:

Lives alone? Y / N

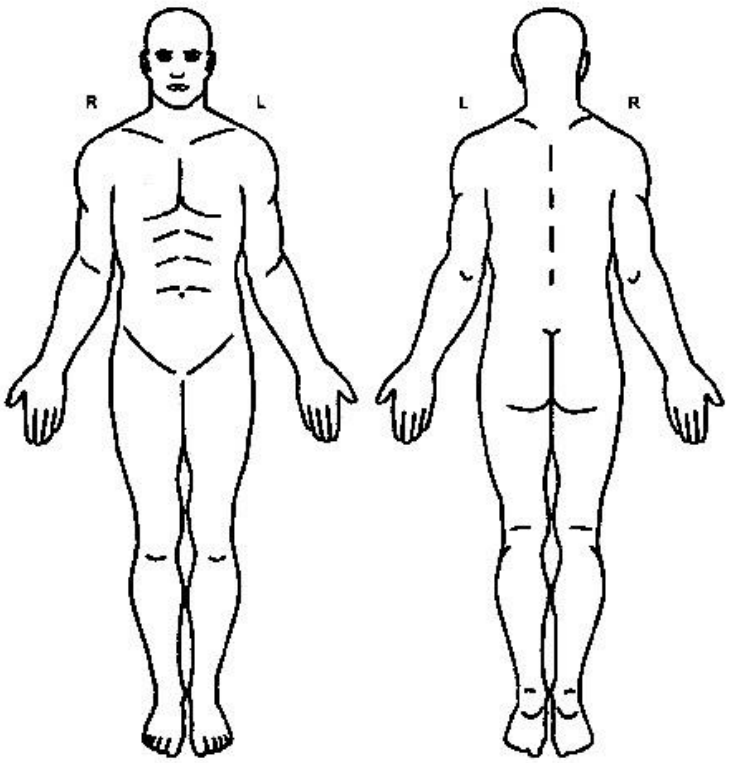
Who is at home that helps you?

Hazards identified at home?

(SEE BACK)

PMH	***Additional Information***	***RECOMMENDED DISCIPLINE IF NEEDED, AND REASON***
Hosp in the last 6 months, exacerbation of illness, or why is home health ordered? ***All Past Surgical History & When***	***SN FREQUENCY***	

Integumentary



	#1	#2	#3	#4	#5
Location					
Onset Date					
Size					
Drainage					
Odor					
Etiology					
Stage					
Undermining					
Inflammation					
Comments					