NEAR EAST UNIVERSITY HOSPITAL

# ADULT INPATIENT FIRST ASSESTMENT FORM

**Patient's**

| | | |
|---|---|---|
| ■Name, Surname: | ■Patient ID No: | ■Blood Group: |
| ■Gender: ☐ F ☐ M | ■Department: | ■Room No: |
| ■Date of birth: ……/……/…… | ■Admission date: | ■Time: |

■Social Security: ☐Pay Patient ☐ State referral ☐Institution reduced price ☐ Private Insurance

| | |
|---|---|
| ■Age: ■Weigh: ■Length: | ■Marital status: ☐ Married ☐ Single |
| ■**Education level**: | ■Job: |
| ■ **Communication Obstacle:** ☐ No ☐ Yes:_ | ■Requirement of translator ☐ No ☐ Yes |

■ A person and his/her telephone number that can make contact with when needed:

■Where he/she came from to unit: ☐ Home ☐Intensive Care ☐Emergency Service ☐ Other:_
■How he/she came to unit: ☐ Walking ☐Invalid Chair ☐ Stretcher ☐ Other:_
■State of consciousness: ☐ Conscious ☐ Cloudy/confuse ☐Unconscious ☐ Other:_

■**Vital Signs:**
► Body Temp: ºC ► Pulse: min ►Respiration: min ► Blood Pressure:_ mmHg ►SPO2 : _
► Pain ☐ No ☐ Yes ☐ Location- Qualification: ☐ Pain score*_
* :*Pain of the patient marked in accordance with protocol using appropriate scale .*

■**EARLY DIAGNOSIS/DIAGNOSIS:**

■**PROFILE OF PATIENT:**

■ Old diseases: ☐ No ☐ Yes (Specify):

■Old operations: ☐No ☐ Yes (Specify the operation and its date):

■Blood Transfusion? ☐ No ☐ Yes

■Known allergy: ☐ No ☐ Yes (Specify):

■Habits: ☐ No ☐ Yes (Specify with period and frequency):
☐ Smoke: ☐ Drug: ☐ Alcohol : ☐ Other :_

■**Family history - Speciality:** ☐ No ☐ Yes (Specify):

■**Constantly used medicines:** ☐ **No**

| Name of medicine | Dose | Usage | Last usage time | Name of medicine | Dose | Usage | Last usage time |
|---|---|---|---|---|---|---|---|
| 1 | | | | 4 | | | |
| 2 | | | | 5 | | | |
| 3 | | | | 6 | | | |

■Is he/she carrying his/her medicines?: ☐No ☐ Yes ►**If yes;**
☐ Received by a nurse. **The medicines that the patient brought from outside , recorded to Submission and return form.**
☐ The doctor informed.

■Does he/she forget to take medicines? ☐ No ☐ Yes(reason):_

■Nutrition method: ☐ Oral ☐ İ.V. ☐ Other (specify):_
■Herbal treatment? ☐ No ☐ Yes (specify): _

■ Is it necessary to make a special diet because of his/her disease? ☐Yes ☐ No
■Does he/she has any obstacle in nutrition by oral route? ☐Yes ☐ No
■ Is there any unwilled loss of weigh in last 6 months? ☐ Yes ( kg) ☐ No**If any of these questions answered as "yes", the patient has to evaluated by a dietitian.*

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## SYSTEM EXAMINATION*

- Cardiovascular ☐ No problem ☐ Exists:_____
- Respiration ☐ No problem ☐ Exists
- Urinary ☐ No problem ☐ Exists
- Neurology ☐ No problem ☐ Exists:
- Skin ☐ No problem ☐ Exists:
- Gastrointestinal ☐ No problem ☐ Exists:
- Musculoskeletal ☐ No problem ☐ Exists:
- Mouth/Tongue ☐ No problem ☐ Exists:_____
- Sight ☐ No problem ☐ Exists:
- Sleeping pattern ☐ No problem ☐ Exists:
- Hearing/Talking ☐ No problem ☐ Exists:
- Prosthesis ☐ No ☐ Exists:
- Other :

** If one or more problems are determined related with system examination please informed doctor. Dr._____ is informed.*

**Menstruation*** ☐ No ☐ Yes • Frequency: • Last period date : _____

**:After the menarche gynecological diseases will evaluated.*

## DAILY LIFE ACTIVITIES and FUNCTIONAL EVALUATION *

| ACTIVITY | He/she can | He/she can with help | He/she can't | ACTIVITY | He/she can | He/she can with help | He/she can't |
|---|---|---|---|---|---|---|---|
| Food/beverage | ☐ | ☐ | ☐ | Get up from bed & Return to bed | ☐ | ☐ | ☐ |
| Personal hygiene | ☐ | ☐ | ☐ | Relieve his/herself | ☐ | ☐ | ☐ |
| Balanced walking | ☐ | ☐ | ☐ | Other: | | | |

**:For patients over the age of 65 , it has to evaluated more detailed with using system examination guide.*

## RISK OF FALL EVALUATION

☐ No risk ☐ High risk ☐ 65 ↑

## RISK OF DECUBITUS EVALUATION

☐ No risk ☐ Low risk ☐ Moderate risk ☐ High risk

■Limitation need ☐ Yes ☐ No

■Patient ID band ☐ Yes ☐ No:

■Finding that makes think of omission or abuse ☐ Not determined ☐ Determined

■Religious/Cultural values that can affect the care and treatment. ☐ Not determined ☐ Determined

**( If a problem is determined please inform a doctor.)**

■Economic difficulties that can affect the care and treatment period ☐ Not determined ☐ Determined

*( If he/she has economic difficulties please direct to patient services department.)*

## PATIENT DISCHARGE PLAN

■Information about his/her disease: ☐ Has got ☐ Has not got ☐ Partly has

■Existing living conditions: ☐ Live alone ☐ With family ☐ With relatives ☐ With friends ☐ Nursing home

■Place of destination after discharge: Stair number: ☐ Unknown

■Projected discharge support: ☐ Personal care ☐ Home caretaker ☐ Transportation ☐ Oxygen ☐ Other

■Assistant equipment necessity: ☐ No ☐ Yes:

■**Basic Security Precautions were taken*** ☐ **Service Orientation was Provided*** ☐

■**Rights and responsibilities of patient and relatives manual was given** , the patient was informed ☐

**: Service will be according to introduction guide.*

| **REPORTER** ☐ Patient ☐ Patient relative ☐ Other (specify): | **THE NURSE WHO FILLED OUT THE FORM** Date: Time: |
|---|---|
| **Name, Surname:** | **Name, Surname:** **Signature:** |