Name:	Room	Residence:
DOB:	Date	Insurance: Medicare A B SC %

Allergies:
NKDA

Code Status
Full DNR

Consulted for:

HPI:

Allergic Rhinitis		HTN		Other PMHX:	
Anemia		Hyperlipidemia			
Asthma		Hypothyroid			
BPH		Impotence			
CAD		Obesity			
CHF		Osteoporosis			
COPD		Osteoarthritis			
CVA		Prostate CA			
Dementia		Renal failure			
Depression		Urinary Incontinence			
Diabetes					
GERD					

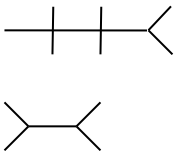
Meds:

Social HX Tob Etoh Drugs Marital: S,M,D,W
Caregiver
Surgical HX
Family HX

Physical	Normal
General	A&A, NAD
Skin	No Breakdown
Eyes	PERLA
ENT	OP clear
Neck	No JVD,Bruit
Breast	Nomasses/ DC
Lungs	CTA Bilat
Heart	RRR No MGR
Abd.	BSactive, NT,ND
Genitalia	
Extrem.	No C/C/E
Psych	**No Delirium**
Neuro	Non Focal

T _____ HR ____RR ____ BP__/____ WT _____
BMI _____Pain _____Site_____

Minicog	
Foley Y/N	
IV's	
Restraints	



Assessment/Plan/ Recommendations

PAIN

Disposition Location ECTC, KTCC, other

Geriatrics syndromes

Advance directives

Social

Rehab

ROS:
General: PAIN,weakness,fatigue, **wtchange**, appetite, **sleep**, chills, fever, night sweats, **Falls**
Resp: Cough, sputum,CP,Dyspnea, wheezing, hemoptysis,
CV: CP, angina, DOE, PND, Orthopnea, LE edema, claudication, syncope, varicosities
GI:N/V,Diarrhea, **constipation**, melena, dysphagia, gas, indigestion, abd pain.
Heme: Anemia,abnl bleeding, easy bruising
GenitoUrinary: Dysuria,hematuria,freq, urg, nocturia, incontinence, Impotence,
Endocrine: Heat/cold intol., voice change, polyuria, polydispsia, polyphagia, glucose monitor
CNS: HA, syncope, seizures, vertigo, paralysis/paresis, musc. Weakness, ataxia.
Psych: Depression, insomnia, memory loss.
Prior functional status:
ADLs: Prior to admission: required help or supervision
With (circle positives)
Bathing, dressing, eating, toileting, transferring, moving around indoors
IADLs Prior to admission-difficulty with (circle positives)
Preparing meals, housework, shopping, transportation, using phone, managing meds, managing finances
Current equipment used @ home
Hospital bed, special mattress, cane, walker, manual w/c, motorized w/c, orthotic, splint
Mini-cog:
Name three objects – **Penny Table Chair**
Ask subject to repeat all three words.
Each correct answer = 1
Repeat until subject learns all three (up to 6 trials)
Number of items recalled after 5 min. _____.
Clock drawing
Draw me a clock that says 1:45 put the hands and numbers on the face so that a child can read it.
Orientation: circle incorrect
Time: Day of Week,Date, month,year,season
Place: hospital, floor, city, county,state

DEPRESSION SCREEN (PRIME MD)
In the last month have you felt
Down, blue or depressed? **YES NO**
Had little interest in your usual activities? **YES NO**
If YES to any of above. Ask about the following sx:
Little interest or pleasure in doing things **YES NO**
Feeling down, depressed, or hopeless **YES NO**
Trouble falling/staying asleep,or sleeping too much **YES NO**
Feeling tired or having little energy **YES NO**
Poor appetite or overeating **YES NO**
Feeling bad about self-failure or let down others **YES NO**
Trouble concentrating on things **YES NO**
Moving or speaking slowly OR being restless **YES NO**
Would be better off dead or of hurting self **YES NO**
Are these symptoms interfering with daily function? **YES NO**

PTSD Screen
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:
1. Have had nightmares about it or thought about it when you did not want to? **YES NO**
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? **YES NO**
3. Were constantly on guard, watchful, or easily startled? **YES NO**
4. Felt numb or detached from others, activities, or your surroundings? **YES NO**