

**CENTRAL STATE HOSPITAL
NURSING REASSESSMENT**

REASON FOR REASSESSMENT: TRANSFER ANNUAL SIGNIFICANT CHANGE IN CLIENT'S CONDITION

Informants: _____

I. Risk Assessment:

Potential Risk	Yes	No	Description of Occurrences/Events since last assessment
Suicidal			
Homicidal			
Physically Aggressive			
Sexually Aggressive			
Escape/Leave without Consent			
Legal Constraint			Explain:

III. Cognitive Assessment:

Today's date? _____ Day of the week? _____
 Your name? _____ Birthday? _____ Age? _____
 Where are you? _____ Who is the President? _____
 Hallucinations: Yes No Describe: _____

Delusions: Yes No Describe: _____

Potential for Violent Behavior:

Self Directed: Yes No Describe: _____
 Directed Toward Others: Yes No Describe: _____

Mood:	Behavior:	Attention Span:
<input type="checkbox"/> Angry <input type="checkbox"/> Sad	<input type="checkbox"/> Argumentative <input type="checkbox"/> Manipulative	<input type="checkbox"/> Good
<input type="checkbox"/> Fearful <input type="checkbox"/> Preoccupied	<input type="checkbox"/> Immature <input type="checkbox"/> Agitated	<input type="checkbox"/> Fair
<input type="checkbox"/> Worried <input type="checkbox"/> Hopeless	<input type="checkbox"/> Histrionic <input type="checkbox"/> Demanding	<input type="checkbox"/> Poor
<input type="checkbox"/> Tense <input type="checkbox"/> Helpless	<input type="checkbox"/> Defensive <input type="checkbox"/> Restless	
<input type="checkbox"/> Calm <input type="checkbox"/> Labile (Rapid shifts)	<input type="checkbox"/> Combative <input type="checkbox"/> Threatening	
<input type="checkbox"/> Depressed <input type="checkbox"/> Withdrawn	<input type="checkbox"/> Irritable <input type="checkbox"/> Impulsive	
<input type="checkbox"/> Anxious <input type="checkbox"/> Euphoric/Elated	<input type="checkbox"/> Inappropriate <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other: _____		

Affect:	Organization of Thought:	Flow of Thoughts:
<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Tangential	<input type="checkbox"/> Normal
<input type="checkbox"/> Blunted	<input type="checkbox"/> Loose Associations	<input type="checkbox"/> Slow
<input type="checkbox"/> Flat	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Rapid
<input type="checkbox"/> Appropriate		<input type="checkbox"/> Blocked
<input type="checkbox"/> Labile		

Speech Patterns:

<input type="checkbox"/> Normal	<input type="checkbox"/> Over-talkative	<input type="checkbox"/> Rapid
<input type="checkbox"/> Word Salad	<input type="checkbox"/> Perseveration	<input type="checkbox"/> Confabulation
<input type="checkbox"/> Evasive	<input type="checkbox"/> Sparse	<input type="checkbox"/> Impoverished
<input type="checkbox"/> Guarded	<input type="checkbox"/> Neologisms	<input type="checkbox"/> Echolalia

Stamp Plate

III. Physical Assessment

Temperature: _____ Pulse: _____ Blood Pressure: _____ Respirations: _____ Height: _____ Weight: _____
 Allergies Yes No
 If yes, describe what and type of Reaction) _____

If applicable, last menstrual period _____ Pregnant: Yes No

CHECK ALL THAT APPLY:

General Appearance:

- Clean, neat, well-groomed
- Unkempt/grooming needs improvement
- Evidence of body odor
- Inappropriately dressed
- Other, specify: _____

Body Posture:

- Erect
- Slumping
- Rigid/Tense
- Other, specify: _____

Hair:

- Color: _____
- Clean/Combed
 - Unclean/Uncombed
 - Matted
 - Parasites/Nits
 - Other, specify: _____

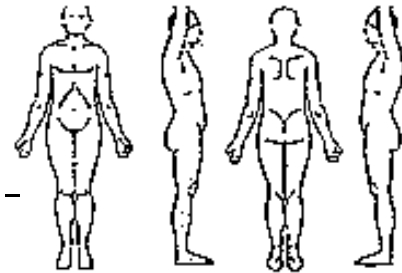
Facial Expression:

- Happy
- Sad
- Angry
- Disinterested
- Frightened
- Confused
- Other, specify: _____

Attitude: Cooperative Uncooperative Hostile Belligerent Uninterested Suspicious

Body Inspection:

- Abrasions
- Burns
- Contusions
- Pressure Ulcers
- Bruises



- Rash
- Incisions
- Parasites
- Lacerations
- Scars
- Tattoos
- Body Piercing
- Other, specify: _____
- No unusual findings

Oral Hygiene:

- Edentulous
- Mouth/Tooth Pain
- Mouth Sores
- Breath Odor
- Other, specify: _____

No significant findings

Indication of pain other than mouth/tooth pain:

YES NO

Nutritional Status:

- Change in weight (10 or more pounds) in last month*
- Vomiting five or more times in the past 24 hours*
- Difficulty swallowing/chewing*
- Difficulty eating*
- Renal Insufficiency*

	Comments
<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Gain <input type="checkbox"/> Loss _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No _____

Stamp Plate

Assistance With Activities of Daily Living Needed (Check the ones that apply):

Feeding Grooming Bathing Mobility No assistance needed
 Toileting Dressing Brushing Teeth Other _____

Physical Disabilities (Check those that apply):

Prosthesis Yes No Specify: _____

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments
<i>Problems with ambulation, balance/falls, or position</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Impairment of musculo-skeletal system that impedes function</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Functional deficit that requires adaptive equipment</i>	<input type="checkbox"/>	<input type="checkbox"/>	Equipment: _____
<i>Upper extremity condition that impedes function</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Sensorimotor deficit that impedes function</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Hearing Deficit</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Requires loud tone or touch to get attention</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Uses loud tone of voice</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Speech is incoherent/slurred/unintelligible</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Aphasic</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Requires gestures/sign language/written word to communicate</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Visual Deficit (wears glasses <input type="checkbox"/> contacts <input type="checkbox"/>)</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Requires braille to communicate</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<i>Changes in medical history for client and family</i>	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____

Health problems that might benefit from leisure activities: Yes No **Comments:** _____

IV. Treatment Compliance

Compliant with prescribed current medication regime? Yes No

Explain "no" answer: _____

Currently experiencing difficulty with drug therapy (drug-drug interaction, drug-food interaction, adverse drug reaction) Yes No

Current response to Nursing Interventions: _____

Are you currently on a study medication? Yes No **Comments:** _____

V. Learning Needs:

Change in learning needs: Yes No **Explain:** _____

VI. Biopsychosocial Issues:

Physical, psychosocial or emotional condition which may preclude the use of restrictive procedures? Yes No

Explain: _____

Medical, physical or behavioral indications of abuse/neglect Yes No

Explain: _____

Pertinent Religious/Spiritual & Cultural Factors Impacting Illness/Treatment: _____

Needs assistance in structuring leisure time Yes No

May benefit from enriched activity program Yes No

Nurse Signature & Title: _____

Date: _____

REASSESSMENT SUMMARY

Strengths/Assets: _____

Needs: _____

Primary Problems: _____

Secondary Problems: _____

Education/Self-care Teaching Needs: _____

Discharge Plans: _____

Nurse Signature & Title: _____
Date: _____

Stamp Plate

