

XXX Hospital

Address

The individual's Identification

**ADMISSION ASSESSMENT: Adult Mental Health & Forensics
(Computer Version)**

PART ONE – PHYSICIAN INTAKE ASSESSMENT (TO BE COMPLETED BY THE ADMISSIONS PHYSICIAN FOR EVERYONE WHO PRESENTS TO THE ADMISSIONS AREAS)

DEMOGRAPHICS

Individual's Name: _____ DOB: _____

Service: Adult Mental Health Forensics

Family and/or significant other(s) accompanying individual upon admission: No Yes (specify name and relationship to individual):

COMMUNICATION

Primary Language:

verbal uses gestures to communicate other (specify):
 does not speak, read, or understand English* uses sign language to communicate*

*LEP/SI Coordinator Contacted: N/A Yes No (explain):

Unable to assess communication (reason):

SOURCES OF INFORMATION

Interpreter present: N/A Yes No (explain):

Interview with the following (check only those which apply):

- Individual
- Family member(s) (specify name and relationship to individual):
- Friends (specify name and relationship to individual):
- Other persons (specify name and relationship to individual):

Review of records (specify):

Other sources (if applicable):

CHIEF COMPLAINT (Give a verbatim statement from the individual [e.g., "I hear voices", "I don't know"], and/or a statement from a family member/ legal guardian, if the individual is not participating).

HISTORY OF PRESENT ILLNESS (Include reason for referral/admission. Include a description of the specific incident leading to this referral/admission, precipitants to the episode of decompensation, onset of symptoms, a listing of pertinent psychiatric symptoms the individual is or is not experiencing, and treatment attempts for this episode, if applicable).

PERTINENT PSYCHIATRIC HISTORY

SUBSTANCE ABUSE HISTORY

Smoking: Unknown at this time Never Past History (when): _____ Current: _____ packs/day

Alcohol: Unknown at this time Never Past History (when): _____ Current: _____ drinks/day

Illicit Drugs: Unknown at this time Never Past History(name/type and when):
 Current (name/type and amount daily):

Other: None/Never Past History(name/type and when):
 Current(name/type and amount daily):

History of DTs: No Yes (when):

History of Withdrawal Seizures: No Yes (when):

Medical/Complications of Substance Abuse: No Yes (what):

Comments (address risk for withdrawal, potential for medication seeking, and need for further assessment):

Unable to assess substance abuse history (reason):

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PERTINENT PSYCHIATRIC FAMILY HISTORY

Describe findings (include family member's relationship to individual and other pertinent details):

Unable to assess pertinent psychiatric family history (reason):

PERTINENT SOCIAL HISTORY

Describe (marital status, current living arrangements, who else lives with this person, employment status, source of income):

Unable to assess pertinent social history (reason):

MENTAL STATUS EXAM (check all that apply)

Appearance & Behavior

- Clean, well groomed Dressed appropriately Dressed Inappropriately Disheveled
 Average height Short Tall Muscular Thin Obese
 Cooperative Not cooperative Hostile Engaging Frustrated Collaborative
 Demanding Other (describe):

Posture & Movements

- Erect Rigid, tense Slumped Other (describe):
 Normal gait Abnormal gait (describe):
 Normal movements Slowed movements Hyperactive Pressured movements Tremor
 Mannerisms Tics Lip smacking Hand wringing Other:
 Describe abnormal movements:

Speech

- Normal volume, rate and tone Spontaneous Loud Pressured Hypervocal
 Stuttering Slurred Incoherent Mute Poverty of speech Other:

Mood

- Euthymic Depressed Anxious Angry Irritable Euphoric Frightened
 Pleasant Other:

Affect

- Appropriate Not appropriate Congruent Incongruent Constricted Labile
 Blunted Flat Depressed Sad Hopeless Other:

Thought Content

- Without aberration Paranoid Ideas of reference Delusions
 Thought insertion Thought broadcasting Ideas of influence Neologisms
 Suicidal Homicidal Obsessions Other:
 Describe positive findings:

Thought Process

- Logical Coherent Concrete Goal directed Tangential Circumstantial
 Flight of ideas Disorganized Loose associations Word salad Thought blocking
 Grandiosity Derealization Depersonalization Other:
 Describe positive findings:

Perceptual Disturbance

- None reported Auditory Visual Tactile Olfactory Gustatory Illusions
 Other:
 Describe positive findings:

Cognitive Function

- Awake/alert Sleepy/sedated/Lethargic Oriented to: Person Place Time Situation
 Estimate of Intellectual Functioning: Average Below average Above average
 Immediate recall: 0 1 2 3 objects Recent memory: 0 1 2 3 objects after 5 minutes
 Remote memory (e.g. date of birth): Good Fair Impaired
 Other:

Insight

- Good understanding of own illness Limited understanding of own illness
 No understanding of own illness

Judgment

- Intact/Appropriate Impaired Unable to assess (reason):

Other MSE Comments (Include a description of any areas unable to assess, along with reason):

BEHAVIORAL RISKS SCREENING

SUICIDE RISK ASSESSMENT – RISK OF SUICIDE/VIOLENCE TO SELF (check all that apply):

Unable to complete at this time due to individual's mental status No suicidal ideation or intent present at this time

Suicidal ideation expressed by individual

Suicidal intent expressed by individual

Realistic plan to harm self in the community

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- Suicidal ideation alleged by others Suicidal intent alleged by others Realistic plan to harm self in the hospital

DESCRIPTION OF THOUGHTS OF SELF-HARM:

HISTORY OF SELF HARM (especially in past six months):

RISK FACTORS:

HISTORICAL FACTORS:

Yes No

- Prior suicide attempts
- Family Hx of suicide/attempts
- Anniversary of major loss
- Family of origin violence
- Victim of physical/sexual abuse
- Domestic partner violence
- Intentional self-injurious behavior
- Access to/hx of use of firearms
- Hx of or current dx of PTSD
- Other: _____

CLINICAL FACTORS:

Yes No

- Severely depressed
- Hopelessness
- Severe anxiety and/or agitation
- Anhedonia
- Co-morbid A&D abuse/dep.
- Command hallucinations
- Chronic pain
- Impulsivity
- Insomnia
- Delirium / Cog. deficits
- Other: _____

DEMOGRAPHIC FACTORS:

Yes No

- Male
- 65 or older
- 85 or older
- Low socioeconomic status
- Living alone
- Currently divorced
- Caucasian or Native American
- Unemployed
- Lack of religion/spirituality
- Other: _____

LOSS FACTORS:

Yes No

- ↓ in voc / academic status
- ↓ of significant relationship
- ↓ in physical health / recent dx
- ↓ of freedom due to legal status
- Financial problems
- Humiliation
- Other: _____

RISK REDUCTION FACTORS:

Yes No

- Positive social support
- Responsible for children <18 y/o
- Sense of responsibility to family
- Living with another person, especially a relative
- Insight
- Positive future orientation
- Eating
- Other: _____

PERSONALITY FACTORS:

Yes No

- Borderline
- Antisocial
- Narcissistic
- Other: _____

OVERALL ASSESSMENT OF SUICIDE RISK:

- None or Low Moderate Risk (Line of Sight is required) High Risk (One-to-one is required)

Explanation, including action taken if moderate or high risk (address pertinent risk responses and mitigating factors, provide rationale for assessment to utilize precautions, take standard precautions, or release individual):

RISK OF VIOLENCE TO OTHERS (check all that apply):

- Unable to complete at this time due to individual's mental status No Violent ideation or intent present at this time

- Violent ideation (physical or sexual) expressed by individual
- Violent ideation (physical or sexual) alleged by others
- Homicidal thoughts by the individual

- Violent intent (physical or sexual) expressed by individual
- Violent intent (physical or sexual) alleged by others

- Plan to harm others (physically or sexually) in the community
- Plan to harm others (physically or sexually) in the hospital

DESCRIPTION OF THOUGHTS TO HARM OTHERS:

HISTORY OF VIOLENCE (Including sexual violence. Note especially any violence within the past six months.):

IMMINENT CLINICAL RISK FACTORS:

Yes No

- Agitated behavior
- Fear or anger
- Threats made face to face
- Specific threats
- Substance abuse or dependence
- Access to weapons

Psychotic symptoms:

Yes No

- Paranoid or persecutory delusions
- Delusions associated with fear, anger, or anxiety
- Delusions that have been acted on before
- Command hallucinations to harm others
- Other: _____

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Hx of or current dx of PTSD

OVERALL RISK OF VIOLENCE TO OTHERS:

None or Low Moderate Risk (Line of Sight is required) High Risk (One-to-one is required)

Explanation, including action taken if moderate or high risk (address pertinent risk responses & mitigating factors, provide rationale for assessment to utilize precautions, take standard precautions, or release individual):

TRAUMA HISTORY (history of physical and/or sexual trauma):

Yes No **Physical abuse** Yes No **Sexual abuse** Yes No **Emotional Abuse**

Trauma history could not be completed at the time of admission (unable/unwilling).

Trauma history completed; there **is** reason to believe trauma is a treatment issue at this time.

Trauma history completed; there is **no** reason to believe trauma is a treatment issue at this time.

SUMMARY regarding TRAUMA HISTORY:

RISK OF VICTIMIZATION:

Yes No – Risk of **being** victimized - check all that apply: Physical abuse Sexual abuse Emotional Abuse

Yes No – Risk of **victimizing others** - check all that apply: Physical abuse Sexual abuse Emotional Abuse

SUMMARY regarding RISK OF VICTIMIZATION:

CURRENT MEDICATIONS (list current meds) – OR – REFER TO MEDICATION RECONCILIATION DOCUMENT

BRIEF REVIEW OF SYSTEMS

Does the individual have any current medical or physical complaints?

No Yes

Unable to elicit information (reason):

If yes, list complaints:

ALLERGIES & ADVERSE DRUG REACTIONS (ADR's)

Substance Category	Presence of Known Allergies	*Specific Substance Name	*Description of Allergic Reaction (signs & symptoms)
Medication	<input type="checkbox"/> No known <input type="checkbox"/> Yes* (list)		
Food	<input type="checkbox"/> No known <input type="checkbox"/> Yes* (list)		
Environmental	<input type="checkbox"/> No known <input type="checkbox"/> Yes* (list)		
Other (e.g., latex, tape)	<input type="checkbox"/> No known <input type="checkbox"/> Yes* (list)		

Previous Adverse Drug Reactions: No Yes (describe):

DIAGNOSTIC IMPRESSIONS (Include diagnostic codes, if applicable)

AXIS I:

AXIS II:

AXIS III:

Other Medical Conditions:

AXIS IV: Psychosocial and Environmental Problems (*check all that apply*)

- | | |
|--|--|
| <input type="checkbox"/> Problems with primary support group | <input type="checkbox"/> Problems related to the social environment |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Occupational problems |
| <input type="checkbox"/> Housing problems | <input type="checkbox"/> Economic problems |
| <input type="checkbox"/> Problems with access to healthcare services | <input type="checkbox"/> Problems related to interaction with the legal system/crime |
| <input type="checkbox"/> Other psychosocial and environmental problems | |

AXIS V: Global Assessment of Functioning (GAF): _____

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DISPOSITION

ADMIT (Skip below and proceed to PART TWO) DO NOT ADMIT (Complete the rest of PART ONE)

TRANSFER TO: _____
 PLACE IN TEMPORARY OBSERVATION (Go to Temporary Observation Intake Assessment)
 RELEASE TO COMMUNITY/NON-ADMIT

RATIONALE FOR DISPOSITION AND PLAN:

**ADMISSIONS
PHYSICIAN/APRN**

PRINTED NAME

SIGNATURE WITH PROVIDER NUMBER

DATE AND TIME

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PART TWO (TO BE COMPLETED BY THE PHYSICIAN AND RN FOR INDIVIDUALS WHO ARE ADMITTED TO THE HOSPITAL)

PHYSICIAN ASSESSMENT

SOURCES OF INFORMATION

Interpreter present: N/A Yes No (explain):

Interview with the following (check only those which apply):

- Individual
- Family member(s) (specify name and relationship to individual):
- Friends (specify name and relationship to individual):
- Other persons (specify name and relationship to individual):
- Review of records (specify):
- Other sources (if applicable):

PERTINENT FAMILY MEDICAL HISTORY

Medical: No known Cancer Myocardial Infarction before the age of 40 Other _____

Describe findings: (include family member's relationship to individual and other pertinent details):

PAST MEDICAL/SURGICAL HISTORY

Public Health History: (check all that apply)

- Positive TB skin test or History of TB – When _____
- Exposure to STDs, MRSA, unspecified viral illness within 2 weeks of admission
- History of Hepatitis B and/or C – When _____
- History of Immunizations up to date
- Previous testing for HIV (specify date and results if known): _____
- Other _____
- No significant public health history

Other Medical History: No significant other medical history

Describe findings:

Other Surgical History: No significant other surgical history

Describe findings:

Other Injuries: No significant other injuries

Describe findings:

Head Trauma: No significant head trauma

Describe findings:

REVIEW OF SYSTEMS Check the box if the individual is experiencing the following problems at the present time or within the last 2-4 weeks, as indicated by the individual, staff, or chart review:

- GENERAL:** fever chills weakness
 weight loss weight gain pain anywhere
 excessive fatigue sleep problems
 sleep apnea
 Other: _____ No complaints
 Unable to assess: _____
 Comments: _____

- GU:** dysuria urgency frequency hesitancy
 incontinence flank pain nocturia hematuria
 vaginal discharge abnormal vaginal bleeding
 post-menopausal
 penile discharge sexual dysfunction
 Sexually active? No Yes
 If yes, using birth control? No Yes
 If yes, type: _____
 Pregnant? No Yes Maybe LMP: _____
 Other: _____ No complaints
 Unable to assess: _____

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		Comments: _____ ***Order HCG on females <50 years old***
EYES: <input type="checkbox"/> change in eyesight <input type="checkbox"/> double vision <input type="checkbox"/> blurred vision <input type="checkbox"/> cataracts <input type="checkbox"/> pain in eyes <input type="checkbox"/> itchy, red eyes <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	MUSCULOSKELETAL: <input type="checkbox"/> new bone or joint pain <input type="checkbox"/> back problems <input type="checkbox"/> arthritis <input type="checkbox"/> weakness <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	
ENT: <input type="checkbox"/> ringing in ears <input type="checkbox"/> earache <input type="checkbox"/> hearing aid <input type="checkbox"/> nasal congestion <input type="checkbox"/> runny nose <input type="checkbox"/> nose bleeds <input type="checkbox"/> sore throat <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> hoarseness <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	INTEGUMENT: <input type="checkbox"/> skin lesions <input type="checkbox"/> rash <input type="checkbox"/> itching <input type="checkbox"/> lumps <input type="checkbox"/> tattoos <input type="checkbox"/> scars <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	
MOUTH: <input type="checkbox"/> tooth ache <input type="checkbox"/> dentures <input type="checkbox"/> oral lesions <input type="checkbox"/> sore/bleeding gums <input type="checkbox"/> loose/missing teeth <input type="checkbox"/> dry mouth <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	NERVOUS SYSTEM: <input type="checkbox"/> syncope/fainting <input type="checkbox"/> focal weakness <input type="checkbox"/> headaches <input type="checkbox"/> dizziness <input type="checkbox"/> shaking or muscle twitches <input type="checkbox"/> problems with balance <input type="checkbox"/> falls <input type="checkbox"/> memory loss <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	
RESPIRATORY: <input type="checkbox"/> SOB <input type="checkbox"/> cough <input type="checkbox"/> sputum <input type="checkbox"/> wheezing <input type="checkbox"/> hemoptysis <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	ENDOCRINE: <input type="checkbox"/> polyuria <input type="checkbox"/> polydipsia <input type="checkbox"/> polyphagia <input type="checkbox"/> heat/cold intolerance <input type="checkbox"/> libido <input type="checkbox"/> night sweats <input type="checkbox"/> hot flashes <input type="checkbox"/> blood sugar problems <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	
CV: <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> varicose veins <input type="checkbox"/> SOB when laying down <input type="checkbox"/> peripheral edema <input type="checkbox"/> calf pain during/after walking <input type="checkbox"/> fainting spells/syncope <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	HEMOTOLOGIC/LYMPHATIC: <input type="checkbox"/> anemia <input type="checkbox"/> bleeding disorder <input type="checkbox"/> bruise easily <input type="checkbox"/> adenopathy <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	
GI: <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> pain <input type="checkbox"/> black, tarry stools <input type="checkbox"/> blood on stools <input type="checkbox"/> rectal bleeding <input type="checkbox"/> vomiting blood <input type="checkbox"/> constipation <input type="checkbox"/> jaundice <input type="checkbox"/> heartburn <input type="checkbox"/> perianal itching <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	ALLERGY/IMMUNOLOGY: <input type="checkbox"/> Prone to infections <input type="checkbox"/> urticaria <input type="checkbox"/> hayfever <input type="checkbox"/> Corticosteroid use, chronic <input type="checkbox"/> Other: _____ <input type="checkbox"/> No complaints <input type="checkbox"/> Unable to assess: _____ Comments: _____	
REVIEW OF SYSTEMS SUMMARY:		
PHYSICAL EXAMINATION (check only those that apply):		
VITAL SIGNS AND OTHER MEASUREMENTS	Height: _____ feet _____ inches Weight: _____ pounds Waist Circumference: _____ inches Temperature: _____ °F Pulse: _____ Respiratory Rate: _____ Blood Pressure: _____ <input type="checkbox"/> unable to assess (reason): _____	
GENERAL	<input type="checkbox"/> well-developed <input type="checkbox"/> well nourished <input type="checkbox"/> no distress <input type="checkbox"/> cooperative <input type="checkbox"/> not cooperative	

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APPEARANCE	<input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> Unable to assess (reason): _____
HEAD	<input type="checkbox"/> normocephalic <input type="checkbox"/> atraumatic <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____
EYES	<input type="checkbox"/> lids normal <input type="checkbox"/> conjunctiva clear <input type="checkbox"/> PERRL <input type="checkbox"/> irises normal <input type="checkbox"/> sclera white <input type="checkbox"/> fundi normal <input type="checkbox"/> uncooperative for fundus exam <input type="checkbox"/> fundi poorly visualized <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____
EARS, NOSE, MOUTH, THROAT	<input type="checkbox"/> external ears normal shape, size and location <input type="checkbox"/> nares patent <input type="checkbox"/> nasal septum normal <input type="checkbox"/> EAC's clear, no lesions <input type="checkbox"/> TM's normal <input type="checkbox"/> hearing grossly intact <input type="checkbox"/> lips normal <input type="checkbox"/> teeth intact <input type="checkbox"/> no caries <input type="checkbox"/> edentulous <input type="checkbox"/> some teeth missing <input type="checkbox"/> gums pink with no bleeding/lesions <input type="checkbox"/> palate intact, no cleft <input type="checkbox"/> throat pink, no lesions or exudate <input type="checkbox"/> tonsils normal in size <input type="checkbox"/> tonsils absent/atrophied <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____
NECK	<input type="checkbox"/> supple <input type="checkbox"/> no masses <input type="checkbox"/> thyroid normal <input type="checkbox"/> non-tender <input type="checkbox"/> full ROM w/o pain <input type="checkbox"/> no JVD <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____
CHEST, RESPIRATORY	<input type="checkbox"/> chest symmetric <input type="checkbox"/> respiratory effort normal/not labored <input type="checkbox"/> lungs clear to auscultation <input type="checkbox"/> no rales <input type="checkbox"/> no rhonchi <input type="checkbox"/> no wheezes <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____
BREAST	<input type="checkbox"/> no nipple discharge <input type="checkbox"/> skin normal – no dimpling or open lesions <input type="checkbox"/> non-tender <input type="checkbox"/> no masses <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____ <input type="checkbox"/> breast examination not clinically indicated based on ROS <input type="checkbox"/> breast examination contraindicated by individual's mental status at this time
HEART	<input type="checkbox"/> RRR <input type="checkbox"/> no murmur, gallop, rub <input type="checkbox"/> no edema PULSES: <input type="checkbox"/> carotid normal <input type="checkbox"/> abdominal aorta normal <input type="checkbox"/> femoral normal <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____
GI	<input type="checkbox"/> abdomen non-tender <input type="checkbox"/> no masses <input type="checkbox"/> soft, no guarding <input type="checkbox"/> no rebound <input type="checkbox"/> liver edge sharp <input type="checkbox"/> liver edge at right costal margin <input type="checkbox"/> spleen not palpable <input type="checkbox"/> no hernia <input type="checkbox"/> non-distended <input type="checkbox"/> bowel sounds present in all 4 quadrants Rectal: <input type="checkbox"/> no mass <input type="checkbox"/> normal tone <input type="checkbox"/> refused rectal exam <input type="checkbox"/> no hemorrhoids <input type="checkbox"/> rectal exam not indicated based on review of systems <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____
GU - FEMALE	<input type="checkbox"/> no lesions of the external genitalia <input type="checkbox"/> no vaginal discharge <input type="checkbox"/> no urethral discharge <input type="checkbox"/> no CVA tenderness <input type="checkbox"/> pelvic exam not indicated based on review of symptoms <input type="checkbox"/> genital exam not indicated based on review of systems <input type="checkbox"/> refused genital exam <input type="checkbox"/> genital/pelvic exam indicated and referred to: _____ <input type="checkbox"/> abnormal/other: _____ <input type="checkbox"/> unable to assess (reason): _____
GU - MALE	<input type="checkbox"/> testes normal size <input type="checkbox"/> no testicular masses <input type="checkbox"/> no lesions of penis <input type="checkbox"/> no urethral discharge

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DIAGNOSTIC IMPRESSIONS (Include diagnostic codes, if applicable)

AXIS III:

Other Medical Conditions:

ADMITTING PHYSICIAN/APRN	_____ PRINTED NAME	_____ SIGNATURE WITH PROVIDER NUMBER	_____ DATE AND TIME
ADMITTING PHYSICIAN/APRN #2 (if applicable)	_____ PRINTED NAME	_____ SIGNATURE WITH PROVIDER NUMBER	_____ DATE AND TIME

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NURSING ASSESSMENT

SOURCES OF INFORMATION

Interpreter present: N/A Yes No (explain):

Interview with the following (check only those which apply):

- Individual
- Family member(s) (specify name and relationship to individual): _____
- Friends (specify name and relationship to individual): _____
- Other persons (specify name and relationship to individual): _____

Review of records (specify):

Other sources (if applicable):

BOWEL MANAGEMENT

Bowel Management Problems? None Unable to assess (explain reason): _____

Prune/Other juice Bran Daily Laxative Laxative PRN Enemas Suppositories Other: _____

Date of last bowel movement: _____ or Unknown

Comments:

PERSONAL SAFETY INTERVIEW

Personal Safety Interview form completed at the time of admission? Yes No (explain why not): _____

If not done at the time of admission, to whom has this responsibility been referred? _____

NURSING SKIN ASSESSMENT

No abnormalities or alteration in skin integrity observed.

Unable to assess skin integrity (explain reason):

Alteration in skin integrity observed (Check all that apply. Indicate location(s) of each observation. Describe any positive findings in the section below).

- | | |
|--|---|
| <input type="checkbox"/> abrasions: | <input type="checkbox"/> burns: |
| <input type="checkbox"/> cuts/lacerations: | <input type="checkbox"/> staples/sutures: |
| <input type="checkbox"/> bruises: | <input type="checkbox"/> track marks: |
| <input type="checkbox"/> open wounds: | <input type="checkbox"/> birthmarks: |
| <input type="checkbox"/> pressure ulcers: | <input type="checkbox"/> moles: |
| <input type="checkbox"/> discolorations: | <input type="checkbox"/> tattoos: |
| <input type="checkbox"/> rash: | <input type="checkbox"/> body piercings: |
| <input type="checkbox"/> lesions: | <input type="checkbox"/> scars: |
| <input type="checkbox"/> redness: | <input type="checkbox"/> other (describe) : |

Describe findings:

NURSING TRIGGER FOR PAIN ASSESSMENT – ACUTE AND CHRONIC

Acute:

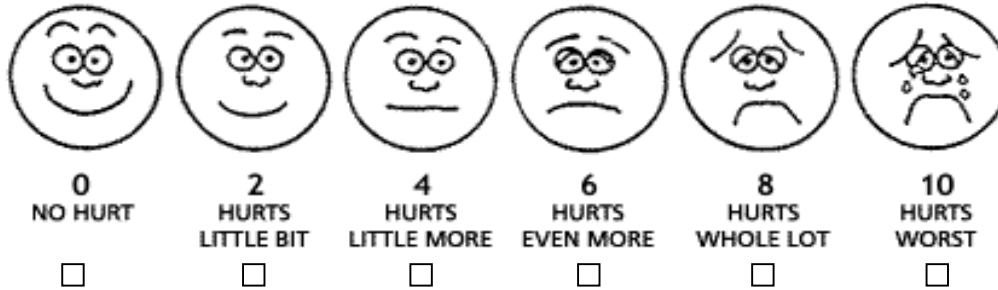
- Are you currently in pain? **OR** Does the individual appear to be in pain? Yes No
If yes, go to next bullet; if no, acute pain assessment trigger is complete.
- Where is your pain? **OR** Where does it appear the individual is in pain? _____
- How bad is your pain? **OR** What level of pain intensity does the individual appear to have?
Mark response on pain intensity scale below in the appropriate box and complete full pain assessment:

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Comprehensive Pain Assessment document completed: N/A Yes No (explain): _____

Chronic:

Does individual have chronic pain? Unable to assess (explain rationale): _____

No Yes If yes, complete the following:

Source of chronic pain: _____

Manner of expressing pain: _____

Pain normally increased by: _____

Pain normally relieved by: _____

Observable signs and symptoms/behaviors indicative of pain: _____

Other comments: _____

Describe findings:

ACHIEVEMENT/FUNCTIONAL STATUS

Activities of Daily Living (ADL's) and Mobility:

Independent with all ADL's and areas of mobility Unable to assess ADL's and Mobility (explain reason): _____

Needs assistance with the following ADL's or areas of mobility:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bathing/showering | <input type="checkbox"/> Sitting | <input type="checkbox"/> Choosing appropriate clothes |
| <input type="checkbox"/> Toileting (bladder &/or bowel) | <input type="checkbox"/> Standing | <input type="checkbox"/> Dressing/Undressing |
| <input type="checkbox"/> Brushing teeth/Oral hygiene | <input type="checkbox"/> Walking | <input type="checkbox"/> Care of clothing |
| <input type="checkbox"/> Grooming/hair care | <input type="checkbox"/> Transferring | <input type="checkbox"/> Bed making |
| <input type="checkbox"/> Shaving | <input type="checkbox"/> Eating/drinking | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Medical treatments | |
| <input type="checkbox"/> Menstrual care | <input type="checkbox"/> Communicating needs | |

Describe findings (include level/type of assistance needed for each ADL and area of mobility marked):

Assistive and Prosthetic Devices Used by Individual (mark all that apply below):

- | | | | | |
|--|-------------------------------------|---|---|---|
| <input type="checkbox"/> none | <input type="checkbox"/> walker | <input type="checkbox"/> glasses | <input type="checkbox"/> dentures, full | <input type="checkbox"/> orthopedic shoes |
| <input type="checkbox"/> artificial limb | <input type="checkbox"/> wheelchair | <input type="checkbox"/> contact lenses | <input type="checkbox"/> dentures, upper | <input type="checkbox"/> ostomy devices |
| <input type="checkbox"/> cane | <input type="checkbox"/> pacemaker | <input type="checkbox"/> hearing aid, left | <input type="checkbox"/> dentures, lower | <input type="checkbox"/> urinary catheter |
| <input type="checkbox"/> crutches | <input type="checkbox"/> VNS | <input type="checkbox"/> hearing aid, right | <input type="checkbox"/> dental appliance | <input type="checkbox"/> other (describe below) |

Comments:

Unable to assess Assistive and Prosthetic Devices (explain reason):

PHYSICAL AND NUTRITIONAL SUPPORT (PNS) RISK SCREEN: Complete all sections of the Risk Screen (A, B, C, and D) within 8 hours of admission. Mark Y (Yes), N (No), or U (Unknown) for all risk factors in each section; do not leave any blanks. Use several sources of information, including individual and family/significant other report, other hospital staff, and current and past medical records. Mark "Unknown" only if unable to find information from any available source. Make notifications if the individual is determined to be at potential risk, and document as indicated below.

A. Choking and Aspiration Risk

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(Any) history of aspiration pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
History of choking incident (within the past five years)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
History of stroke (within the past year only)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Current dysphagia diagnosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Droling with difficulty managing secretions	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Edentulous <u>or</u> acute dental issues which may impact chewing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Difficulty swallowing or chewing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Altered level of consciousness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Dysphasia/slurred speech	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Currently receives non-oral nutrition, medication, and/or hydration	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
B. Fall Risk	
Fall within the past six months	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Altered level of consciousness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Dementia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Seizure disorder with one or more seizures in the past 6 months	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Movement disorder	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Report of dizziness, lightheadedness or lower limb weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Uses assistive device and/or wheelchair for mobility <u>or</u> requires total assistance for mobility and transfer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Incontinence <u>or</u> nocturia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Shuffling or unsteady gait	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Blind <u>or</u> non-corrected visual impairment (e.g., needs glasses but does not wear)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
C. Decubitus Ulcer Risk	
Confined to bed	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Requires use of a wheelchair for mobility	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
(Any) history of a pressure ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Observation of reddened areas over bony prominences	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Incontinence	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
D. Nutritional Risk	
Diabetes mellitus (new onset <u>or</u> insulin-requiring) <u>or</u> diabetes insipidus	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Anorexia or bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Current decubitus ulcer or non-healing wound	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Receives dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Severe or multiple food allergies (e.g., rash, difficulty breathing)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Unintentional weight loss/gain of 10 pounds or more in the past month	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Receives non-oral nutrition, hydration, and/or medication	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Recent unexplained decrease in food/fluid intake	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Excessive water intake	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Pregnant or lactating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Hallucinations and/or delusions that impact nutritional status (e.g., thinks food is being poisoned; hears voices saying not to eat)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
<p>SUMMARY OF PNS RISK SCREEN FINDINGS: If one or more risk factors within a section is marked "yes", the individual is at <u>potential</u> risk for that condition, and further assessments and notifications are required. Based on the above findings, the individual is at potential risk for:</p> <p>Choking and aspiration? <input type="checkbox"/> N <input type="checkbox"/> Y – <i>Choking and Aspiration Risk Assessment is indicated; immediately notify physician/APRN and Unit Charge Nurse.</i></p>	

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Fail? N Y – *Fall Risk Assessment is indicated; immediately notify physician/APRN and Unit Charge Nurse*
Decubitus Ulcer? N Y – *Decubitus Ulcer Risk Assessment is indicated; immediately notify physician/APRN and Unit Charge Nurse.*
Nutritional Problems? N Y – *Nutrition Assessment is indicated; immediately notify physician/APRN, Unit Charge Nurse, and dietitian.*

NOTIFICATIONS REQUIRED? N Y *(If yes, complete the information below)*

_____	_____	_____	
Name/title of Physician/APRN notified	Date	Time	
_____	_____	_____	
Name/title of Unit Charge Nurse notified	Date	Time	<input type="checkbox"/> Not applicable
_____	_____	_____	
Name/title of Dietitian notified (if applicable)	Date	Time	<input type="checkbox"/> Not applicable
_____	_____	_____	
Name/title of other staff notified (if applicable)	Date	Time	

INITIAL HEALTH EDUCATION

Initial health education provided to individual and/or family/friend?
 None (explain): _____
 Yes (mark all that apply below, indicating specific materials taught):
 Safety issues: _____
 Orientation to unit: _____
 Medications: _____
 Other: _____
 Comments *(include an evaluation of learning and follow-up education needs, if applicable):*

NURSES' SUMMARY OF FINDINGS

No clinically significant findings.
 Clinically significant findings identified *(Include a synthesis of all clinically significant findings and recommended interventions for treatment and recovery planning):*

ADMITTING RN #1	_____	_____	_____
	PRINTED NAME	SIGNATURE WITH PROVIDER NUMBER	DATE AND TIME

ADMITTING RN #2 (if applicable)	_____	_____	_____
	PRINTED NAME	SIGNATURE WITH PROVIDER NUMBER	DATE AND TIME

"My signature below indicates that I have reviewed the portion of the Admission Assessment that is completed by the Nurse."

PHYSICIAN/APRN	_____	_____	_____
	PRINTED NAME	SIGNATURE WITH PROVIDER NUMBER	DATE AND TIME

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SIGNATURES

Clinicians *Reviewing* the Completed Admission Assessment:

"My signature below indicates that I have reviewed the admission assessment document".

Printed Name	Signature	Title	ID#	Date	Time
		Attending Psychiatrist			
		Unit Nurse (if not admitting nurse)			
		RPT Facilitator			
		Psychologist			