

GENERAL INFORMATION

Admission Date/Time: _____ Admitted from: Home ED SNF Other: _____

How to be addressed: _____ Primary Language: _____ Interpreter Needed: No Yes: _____

Source of Info: Patient Family Chart Interpreter used Other: _____

Marital Status: M S W D Sep Other: _____ Height _____ Stated Measured Weight _____ kg Stated Measured

Emergency Home Phone: _____

Contact: Name: _____ Relationship: _____ Work Phone: _____ Cell Phone: _____

Primary Home Phone: _____

Spokesperson: Name: _____ Relationship: _____ Work Phone: _____ Cell Phone: _____

ADVANCE DIRECTIVES

Advance Directives? Yes No If NO Advance Directive: Information Provided

If YES, copy placed on chart? Yes No Date placed in chart: _____ If not brought in, plan to obtain: _____

If you DON'T have an Advance Directive, who, other than you knows your wishes related to health care? (surrogate)

OR

If you DO have an Advance Directive, NOT BROUGHT WITH YOU today, who did you name as your agent/decision maker?

Name: _____ Relationship: Spouse Other: _____ Home Phone: _____ Alternate Phone: _____

OPTIONAL: Pt's healthcare wishes documented, signed, dated by patient and copy placed on chart: CHECK HERE if completed.

VALUABLES

Patient/Family informed of responsibility for belongings left at bedside.

HISTORY: CURRENT ILLNESS

Admission Diagnosis: _____ Reason you came to the hospital: _____

Patient Goals for Hospitalization: _____ Patient's Expected Length of Hospitalization: _____

Recent ill contacts: No Yes: _____ Recent Travel: No Yes: _____

Primary Care Physician _____ Notified of Admit: No Yes

Specialty Physicians/Clinics	Name	Specialty	Name	Specialty
/Other Providers:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Do you accept blood, blood products, and blood fractions? Yes No If no, Refusal signed? Yes No

Complimentary/Cultural/Alternative Therapies Used: _____

ALLERGIES

Do you have any allergies or intolerances to ANY medications, foods, tapes, dyes or the environment? No Yes (list below):
If yes, allergy/latex alert band on

MEDICATION ALLERGIES	SYMPTOMS/REACTION (e.g. rash, itching, nausea, difficulty breathing, anaphylaxis)

OTHER ALLERGIES	SYMPTOMS/REACTION (e.g. rash, itching, nausea, difficulty breathing, anaphylaxis)
<input type="checkbox"/> Food:	
<input type="checkbox"/> Latex: <input type="checkbox"/> Sensitive <input type="checkbox"/> Allergic	
<input type="checkbox"/> Iodine/Contrast	
<input type="checkbox"/> Tape	
<input type="checkbox"/> Other:	

Red - Should be completed within 8° • Black - Complete within 24° • Shaded - Complete as needed throughout stay



MEMORIALCARE®
LONG BEACH MEMORIAL MEDICAL CENTER

PATIENT PROFILE (ADULT)

GASTRO INTESTINAL	Do you have any STOMACH or INTESTINAL problems? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle/describe): <i>GERD/reflux, ulcers, pancreatitis, gallbladder disease, liver disease, irritable bowel disease (chron's/ulcerative colitis), diverticulitis, hernia, abdominal pain, nausea/vomiting, diarrhea, constipation, incontinence, melena, hemorrhoids.</i>	<input type="checkbox"/> GT <input type="checkbox"/> JT Date Inserted: _____ <input type="checkbox"/> Ileostomy <input type="checkbox"/> Colostomy Appliance Type/Size: _____ Vendor Name _____ Phone: _____ Laxatives/Softeners: _____ Bowel Program: _____													
GU REPRODUCTIVE	Do you have any KIDNEY or URINARY problems? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle/describe): <i>Renal disease, recent UTI, frequency, retention, urgency, hematuria, nocturia, incontinence, painful urination</i> Do you have any MALE problems? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle/describe): <i>Prostate, infections, discharge</i> Do you have any GYNECOLOGICAL problems? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle/describe): <i>Vaginal bleeding, discharge, infections, menopausal symptoms</i> Date of Last LMP: _____ Are you or could you be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ostomy/Urinary Diversion Type: _____ Appliance Size: _____ Catheter type/size: _____ <input type="checkbox"/> Urinary Catheter type/size: _____ Date Last Changed: _____ Vendor Name: _____ Phone: _____ Bladder Program: _____ <input type="checkbox"/> Dialysis Type: PD HEMO Date Last Tx: _____ Dialysis Center: _____ <input type="checkbox"/> AV Shunt Location _____ Date Placed: _____													
SKIN	Do you have any SKIN problems? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle/describe): <i>Rash, itching, lesions/wounds/pressure ulcers/non-healing sores, mole changes, bruising, jaundice, melanoma, shingles/chicken pox, psoriasis</i>	Treatment/Supplies: _____ Vendor Name: _____ Phone: _____													
IMMUNE/HEMATOLOGY BLEEDING/ONCOLOGY	Do you have any history of CANCER or BLOOD DISORDERS? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle/describe): <i>Cancer, anemia, sickle cell, bleeding disorder</i> Do you have any IMMUNE SYSTEM DISORDERS or are you IMMUNE SUPPRESSED? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle/describe): <i>Organ Transplant, steroids, autoimmune disorders, infections (acute/chronic), resistant organism infection (MRSA/VRE/other) location: _____</i>	<input type="checkbox"/> Chemo: _____ Date: _____ <input type="checkbox"/> Radiation: _____ Date: _____ <input type="checkbox"/> Transplant: _____ Date: _____ <input type="checkbox"/> Compression Garment													
ENDOCRINE	Do you have any ENDOCRINE disorders? <input type="checkbox"/> No <input type="checkbox"/> Yes (circle/describe): <i>Diabetes, adrenal insufficiency, pituitary disorder, hyperthyroidism, hypothyroidism, parathyroidism</i>	<input type="checkbox"/> Blood glucose usual range: _____ HgA1c: _____ Date: _____ <input type="checkbox"/> Glucose Monitor Type: _____ <input type="checkbox"/> Insulin Pump Basal rate: _____ Last fill: _____ Vendor Name: _____ Phone: _____													
OTHER	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"> Medical/Mental Health, Chemo/Radiation, Previous Hospitalizations </td> <td style="width:10%;"> Date </td> <td style="width:30%;"> Surgeries, Accidents, Injuries, Fractures </td> <td style="width:10%;"> Date </td> <td style="width:20%;"> Immunizations <table style="width:100%;"> <tr> <td style="width:50%;">Date</td> <td style="width:50%;">Date</td> </tr> <tr> <td>____ Flu</td> <td>____ Hep A</td> </tr> <tr> <td>____ Pneumonia</td> <td>____ Hep B</td> </tr> <tr> <td>____ Tetanus</td> <td>____ Other:</td> </tr> </table> </td> </tr> </table>	Medical/Mental Health, Chemo/Radiation, Previous Hospitalizations	Date	Surgeries, Accidents, Injuries, Fractures	Date	Immunizations <table style="width:100%;"> <tr> <td style="width:50%;">Date</td> <td style="width:50%;">Date</td> </tr> <tr> <td>____ Flu</td> <td>____ Hep A</td> </tr> <tr> <td>____ Pneumonia</td> <td>____ Hep B</td> </tr> <tr> <td>____ Tetanus</td> <td>____ Other:</td> </tr> </table>	Date	Date	____ Flu	____ Hep A	____ Pneumonia	____ Hep B	____ Tetanus	____ Other:	
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COGNITIVE AND PERCEPTUAL Preferred Learning Style: No Preference Reading Explanation Highest Grade Level: _____
 Visual (video, pics) Demo Other _____

Alterations in:	Explanation/Adaptation/Special Needs:	Alterations in:	Explanation/Adaptation/Special Needs:
<input type="checkbox"/> Vision (Impaired, blind) <input type="checkbox"/> None	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other: _____ <i>(circle if brought into hospital)</i>	<input type="checkbox"/> Reading (comprehension, literacy, dyslexia) <input type="checkbox"/> None	
<input type="checkbox"/> Hearing (HOH, Deaf) <input type="checkbox"/> None	<input type="checkbox"/> Hearing Aids: Right Left <input type="checkbox"/> Cochlear Implant <input type="checkbox"/> Sign Language Other: _____ <i>(circle if brought into hospital)</i>	<input type="checkbox"/> Thought Process/Behavior (Mental status changes, memory, judgment, decision making) <input type="checkbox"/> None	
<input type="checkbox"/> Verbal Communication (aphasic) <input type="checkbox"/> None	<input type="checkbox"/> Devices/Techniques: _____ <i>(circle if brought into hospital)</i>	<input type="checkbox"/> Taste <input type="checkbox"/> Touch <input type="checkbox"/> Smell <input type="checkbox"/> None	

PAIN		ACUTE: Do you have pain now?			Do you have CHRONIC pain? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Location							
Intensity Score (0-10)	Score	Scale		Acceptable Comfort Level	Score	Scale	
		<input type="checkbox"/> Numeric	<input type="checkbox"/> Wong Baker Faces			<input type="checkbox"/> Numeric	<input type="checkbox"/> Wong Baker Faces
Description (characteristics, frequency, quality)							
Duration							
What makes better/worse?							

How can one tell you are having pain? _____

What lifestyle changes/adaptions have you made related to managing your pain? _____

SEE DAILY ASSESSMENT

ACTIVITY - EXERCISE / SELF CARE

Are you currently: <input type="checkbox"/> Working <input type="checkbox"/> Retired <input type="checkbox"/> A student <input type="checkbox"/> Not working <input type="checkbox"/> Disabled		Adult Rehabilitation/Functional Screen			
What is your current/former occupation: _____ Do you need help with any of the following: <input type="checkbox"/> Walking <input type="checkbox"/> Getting out of bed <input type="checkbox"/> Going to the bathroom <input type="checkbox"/> Feeding yourself <input type="checkbox"/> None		2 or more checks per discipline = screen or referral ** A check on these items requires screen or referral		Speech and Dysphagia Therapy	** Acute onset slurred or garbled speech/aphasic. ** Recent laryngectomy Recent tracheostomy Recent head injury
Exercise: Type: _____ Amount: _____ Frequency: _____		Physical Therapy Musculoskeletal pain > 6 (0-10 scale) Unexplained fall in last 3 months Acute onset of mobility difficulties Acute onset of general weakness <input type="checkbox"/> None	Occupational Therapy ** Any of above + acute onset of difficulty with ADL's/self-care Do your health problems interfere with your daily activities? <input type="checkbox"/> None		
Screen initiated: ___ PT ___ OT ___ ST/Dys. OR Referral/MD order written: ___ PT ___ OT ___ ST/Dys. Request screen if unsure of therapy needs. Have therapy ordered by MD (w/o screen) if patient needs therapy intervention.					

What activities are important to you (e.g., recreation, hobbies, talents, social, family)? _____

Do you have enough energy to do the things you want to do? Yes No, describe: _____

Transportation: How do you get around town? _____ Who do you live with? Alone With spouse or sig. other/family/hired help (circle)

Current Living Arrangement: House Apartment One story Multi story # of steps to enter: _____
 Acute Rehab SNF Board & care Assisted Living Facility Name: _____
 No permanent address: (explain) _____

Community resources currently utilized (e.g., Meals on Wheels): _____

Where do you expect to go after discharge: _____ Phone #: _____

Physical Barriers at Discharge Destination (i.e., Narrow halls): _____

NUTRITION/METABOLIC

Special Diet/Eating habits (# meals/day, supplements): _____

Restrictions/Intolerances: _____ Food Likes/Dislikes: _____ Breast Feeding/Lactation: NA No Yes

Describe your appetite: _____ Who prepares your meals? _____ Who grocery shops? _____

Dentition: Dentures: Upper Lower Partial None
 (Circle if brought to hospital) Proper Fit of Dentures Yes No: _____

NUTRITIONAL RISK SCREEN: None Indicated Teeth/Oral Status: _____

- Consult NUTRITIONAL SERVICES if any items selected
- Anticipated/actual clear liquids/NPO greater than 5 days
 - Vomiting/nausea/diarrhea greater than 4 days prior to/post admission
 - Loss of appetite greater than 4 days prior to/post admission
 - Difficulty with chewing and swallowing
 - Unintentional weight loss of 10% of usual body weight
 - PPN, TPN, Enteral Tube feeding within past 30 days
 - New Diabetic/DKA
 - Appears severely underweight
 - History of Celiac Disease
- DYSPHAGIA SCREEN:** None Indicated
 Any of the following triggers SPEECH/DYSPHAGIA SCREEN
- Tracheostomy/Laryngectomy w/in 30 days
 - Swallowing difficulty with all food and/or liquids (pocketing, coughing, throat clearing)
 - Recurrent Pneumonia (history of aspiration or right lobe infiltrate in the past year)

HEALTH PERCEPTION/HEALTH MANAGEMENT

Does anything interfere with your ability to follow the advice of your health care providers (e.g., finances, education) No Yes: _____

SLEEP-RELAXATION

What is your normal sleep/rest schedule: _____ Do you feel rested upon waking? Yes No _____

Problems sleeping: Getting to sleep Waking early Sleep walking Snoring Sleep apnea Excessive sleep Other: _____ None

What equipment/aids/routines/meds help you sleep/relax: _____ None

SEXUALITY - REPRODUCTIVE

Concerns about illness/hospitalization/medication impact on sexuality/relationship? No Yes: _____

ROLE RELATIONSHIPS

What is your most significant relationship: _____

What are your primary roles/responsibilities: _____

Anticipated changes because of this illness/surgery (job, family, housing): _____

Do you care for someone in your home (person/pet): No Yes

Whom: _____

Is this a concern: No Yes _____

ASK PRIVATELY

Do you have any issues of physical, emotional, sexual, or financial abuse that you would like to discuss with someone No Yes - Social Services

Do you feel unsafe going back to the place where you are living? No Yes - Social Services

(Additional considerations: unexplained bruises, injury, loss of interest in self, excessive fear, unkept/poor hygiene, resignation)

SELF PERCEPTION - SELF CONCEPT

How would you describe yourself (personality, disposition, mood swings, body image, self-esteem): _____

Have you noticed less interest or pleasure in doing things recently: No Yes: _____

Have you felt down, depressed or hopeless recently: No Yes: _____

COPING - STRESS TOLERANCE

Have you had a recent major change/significant loss/stressor in your life (e.g., marital, death, birth, job change, military, retirement) No Yes: _____

How did you/do you cope with loss, stress, or change: _____

VALUES/BELIEFS/SPIRITUAL CARE

How can we help you carry out your religious, spiritual, or cultural practices while you are here? _____ None stated

What is your faith background: _____ Would you like support from our pastoral care department: No Yes

Would you like your clergy notified of your admission: No Yes, specify: _____

What questions, anxieties, fears or concerns do you have about your health or care? None stated

What information (strengths, activities, routines, habits, expectations, past experiences, family involvement in care) would help us give you more personalized care? _____ None stated

What else do you wish to tell us about yourself that would help us to care for you? None stated

DISCHARGE DISPOSITION

Home/No Needs Home/Needs Home with _____
 Facility Placement to: _____ Patient/Family/LRP agrees with discharge plan

INTERDISCIPLINARY DISCHARGE SUMMARY: patient's status, teaching and comprehension (meds, treatments, equipment, diet, activity)

Problems (resolved, unresolved-action)

- Education Record
 Discharge Instructions

Discharge Date: _____ Time: _____ Initials: _____

Discharge Planning options and process discussed with _____ Name/Relationship _____ Phone _____

Needs		Resource Assessment and Referrals	Referral Complete	
Date	Initials		Date	Initials
		Health Insurance:		
		Financial Assistance:		
		Shelter:		
		Supervision:		
		Caregiver/Attendant Care:		
		Meals on Wheels:		
		Transportation:		
		Support Groups:		
		Other:		
		Other:		
Discharge Assessment and Referrals				
		No Discharge Planning Needs		
		Reassessment Indicates Discharge Planning Needs		
		Supplies Vendor: _____		
		<input type="checkbox"/> Nutritional Supplement <input type="checkbox"/> Enteral <input type="checkbox"/> Diabetic		
		<input type="checkbox"/> Parenteral <input type="checkbox"/> Ostomy/Wound <input type="checkbox"/> Urinary		
		<input type="checkbox"/> _____ <input type="checkbox"/> _____		
		<input type="checkbox"/> Dialysis Facility:		
		<input type="checkbox"/> Ability to Pay Clinic		
		<input type="checkbox"/> DME Vendor: _____		
		<input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Hospital Bed		
		<input type="checkbox"/> Oxygen <input type="checkbox"/> Nebulizer <input type="checkbox"/> Vent: _____		
		<input type="checkbox"/> ADL Equipment: _____ <input type="checkbox"/> _____		
		Non-Medical Placement <input type="checkbox"/> Senior Residence <input type="checkbox"/> Custodial SNF <input type="checkbox"/> _____		
		<input type="checkbox"/> Shelter <input type="checkbox"/> Board and Care <input type="checkbox"/> Assisted Living		
		Interfacility Transfer <input type="checkbox"/> Refer to Interfacility Transfer Form <input type="checkbox"/> Chart Copy Requested		
		<input type="checkbox"/> Acute <input type="checkbox"/> LTAC <input type="checkbox"/> Sub-Acute <input type="checkbox"/> Acute Rehab		
		<input type="checkbox"/> SNF <input type="checkbox"/> Custodial SNF <input type="checkbox"/> Psychiatric Facility		
		Home Health <input type="checkbox"/> LBMMC <input type="checkbox"/> _____		
		<input type="checkbox"/> RN <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> SP <input type="checkbox"/> SW <input type="checkbox"/> Aid		
		<input type="checkbox"/> Parenteral Tx: _____		
		<input type="checkbox"/> Trach <input type="checkbox"/> Vent: _____ <input type="checkbox"/> _____		
		<input type="checkbox"/> Feeding Tube: _____ <input type="checkbox"/> _____		
		<input type="checkbox"/> Ostomy/Wound Care <input type="checkbox"/> _____		
		Hospice <input type="checkbox"/> LBMMC <input type="checkbox"/> _____		
		Outpatient <input type="checkbox"/> Rehab <input type="checkbox"/> LBMMC <input type="checkbox"/> _____		
		<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SP <input type="checkbox"/> _____		
		<input type="checkbox"/> _____ <input type="checkbox"/> _____		

