Day Care Initial Assessment Form

Patient's Name: _____ UID: _____ IPID: _____ Age: _____

Gender: □Male □Female D.O.A: _____ Unit: _____

Date: _____ Time of arrival: _____

PART A (to be filled by Nurse)

Vital Signs:

Temp: _____ Pulse/HR: _____(beats/min) B.P: _____(mm/Hg)

Respiration_____(breaths/min) SpO2: _____ Height: _____(cms)

Weight: _____(kgs) BMI: _____

Any language barrier: □Yes □No If yes, please call interpreter.

Allergies: □Yes □No If yes, specify:

_____

Psychosocial Assessment:

Alcohol Intake: Yes □ No □ Substance Abuse: Yes □ No □ Smoking: Yes □ No □ Do you have any special religious, spiritual or cultural needs to be considered? Yes □ No □ If Yes, Specify details:

_____

PAIN SCREENING

PAIN: Yes□ No□ If Yes, If Yes Score: _____

Pain Scale Used: _____

PAIN CHARACTER: Sharp □ Dull□ Aching□ Burning □

Duration: _____ Location: _____

NUTRITIONAL SCREENING:

Last 3 months appetite: Increased: □ Decreased: □ No Change: □

Last 3 months Weight: Increased: □ Decreased: □ No Change: □

Fall Risk Screening for adults: No Risk

Age more than 65 years □ History of fall in last 3 months □

Walks with assistance □ Any neurological Problem □

In case of 2 more criteria met initiate detailed fall assessment and fall prevention protocol.

Fall Risk Screening (for Paediatrics)

H/O fall in the last 3 months Neurological problem (vertigo, seizure etc) Deranged Mobility No Risk In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol.

Nurse's Signature	Name	Emp. No.	Date	Time:

PART B (to be filled by Physicians) Chief Complaints:				
Past Medical/ Surgical History:				
Personal History:				
Significant Family History:				

Medical Reconciliation:

Source Of Information	Name of the Drug	Dose	Frequency	Route	Date of last dose taken	Time of last dose taken	To be continued		Withhold
							Yes	No	
• Verbally from Patient/Attendant • Discharge Summary • OPD prescription • Not Applicable									
Clinical Examination:									
Provisional Diagnosis:									
Plan of care (Including investigation ordered):									
Doctor's Signature	Name:	Sign:	Date:	Time:					

Disclaimer

The content of the E-mitra is intended to serve as a sample and guide for better understanding the NABH Entry Level Standards. It is not prescribed by NABH as the exclusive or only way to meet the standards. Healthcare organizations are encouraged to adapt and modify the materials according to their own scope of services and operational needs. NABH is not liable for any misinterpretations or errors resulting from the unmodified use of this material, or for any non-compliance during assessments that may arise because of such actions.