# In Patient Department Initial Assessment Form

Adult In-Patient History and Physical Record

| | | | |
|---|---|---|---|
| **Allergies** □Not Known<br><br>known) | □Known: _____ (please mention if | **Height:** | Weight: _____Kg |
| Source of History: □Other: _____ | □Self (Patient) | □Spouse | □ Parent (Father/Mother) |

**History of Present Illness: (Please describe pain location, character, score, duration etc.) Presenting Complaints:**

**History of Present Illness**

**Gynaecologic & Obstetrics History (for female):**

| Menarche | Cycle | Loss | IMB |
|---|---|---|---|
| | | | |

| | | |
|---|---|---|
| **Pain** | **PCB** | **L.M.P.** |
| **Vaginal Discharge** | **Cervical Smear** | **Contraception** |

**Obstetric History:**

**Pertinent Family History:** ☐ **Negative** ☐ **Unknown**

| # | Past Medical History | Duration | # | Past Medical History | Duration |
|---|---|---|---|---|---|
| 1 | | | 7 | | |
| 2 | | | 8 | | |
| 3 | | | 9 | | |
| 4 | | | 10 | | |
| 5 | | | 11 | | |
| 6 | | | 12 | | |
| | Past Surgical History | | | Year | Hospital |
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

**Medication Reconciliation**

| SOURCE of Medication List (Check all that apply) | Drug Name | Dose | Route | Frequency | To be continued in hospital |
|---|---|---|---|---|---|
| ☐ Patient's Medication List | | | | | YES/NO |
| | | | | | YES/NO |
| ☐ Physician's List | | | | | YES/NO |
| ☐ Patient Family recall | | | | | YES/NO |
| ☐ Previous Discharge Papers | | | | | YES/NO |
| ☐ Referring facility | | | | | YES/NO |
| ☐ Pharmacy | | | | | YES/NO |
| ☐ Others | | | | | YS/NO |
| ☐ This Patient is not on any prescriptions, over the counter | | | | | YES/NO |

| | | | | | |
|---|---|---|---|---|---|
| **medications, or herbal remedies**<br><br>**Disposition of medications**<br><br>**□None with patient**<br><br>**□ Sent home with family** | | | | | **YES/NO** |
| | | | | | **YES/NO** |
| | | | | | **YES/NO** |

**SOCIO ECONOMIC STATUS**

**□Business □Service □Self – employed □Any**

**Other CULTURAL/SPIRITUAL & RELIGIOUS**

**□None □Specify, If any - _____**

**LIFESTYLE**

**□Active □Moderate Active □Sedentary - _____**

**TOBACCO: □ None □Yes (Specify) _____**

**ALCOHOL: □ None □Yes (Specify) _____**

**DRUGS: □None □Yes (Specify) _____**

**PHYSICAL EXAMINATION**

**Vitals**

Temperature: _____ $^0$F Pulse Rate: _____/Minute

Respiratory Rate: _____/Minute Blood Pressure: _____/_____mmHg

Pain Score: _____ / 10 Heart Rate: _____/min

$SpO_2$ _____%

**Body Habitus**

□Cachectic □ Average Built □ Overweight □ Obese

(BMI Kg/m $^2$<18) (BMI 18.1 to 22.9 Kg/m$^2$) (BMI 23 to 24.9 Kg/m$^2$) (BMI > 25 Kg/m)

Reference: consensus-statement-for-diagnosis-of-obesity-abdominal-obesity-and-the-metabolic-syndrome-for-Asian-Indians-and-recommendations-for-physical-activity-medical-and-surgical-management

**General**

| | | | | | |
|---|---|---|---|---|---|
| Pallor: | □ Yes | □ No | Icterus: | □ Yes | □ No |
| Cyanosis: | □ Yes | □ No | Lymphadenopathy: | □ Yes | □ No |
| Clubbing: | □ Yes | □ No | Pedal Edema: | □ Yes | □ No |

## SYSTEMIC EXAMINATION

| |
|---|
| Head & Neck: WNL / |
| Cardiac: WNL / |
| Chest / Breast: WNL / |
| Abdomen: WNL / |
| Back: WNL / |
| Genital: WNL / not done due to patient request / done by consult on _____ (date) |
| Rectal: WNL / not done due to patient request / done by consult on _____ (date) |
| Skin / Vascular / Extremities: WNL / |
| Neurologic: WNL / |

## LOCAL EXAMINATION

## PSYCHOLOGICAL (SUICIDAL RISK / SELF – HARM SCREENING)

| ASSESSMENT | ACTION / REFERRAL NEEDED (AS APPLICABLE) |
|---|---|
| **Stable** ☐ **Depressed** ☐<br>**Anxious** ☐ **Irritable** ☐<br>**Uncooperative** ☐<br>**Risk of Suicide / Self Harm** ☐ | **Psychological Counselling**<br>☐ **YES** ☐**NA**<br>**Psychiatric**<br>☐ **YES** ☐**NA**<br>*** Suicidal risk assessment completed**<br>☐**YES** ☐**NA**<br>**If yes, detailed assessment to be done in Form No.9915** |

## PATIENT INFECTION RISK ASSESSMENT

If referred from other Hospital; Hospital Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ City: _ _ _ _ _ _ _ _ If frequently hospitalized; Last date of discharge: _ _ _ _ _ / _ _ _ _ _/ _ _ _ _ _ _

Duration of Stay _____days

| Indwelling Devices | Present | Evidence of Infection |
|---|---|---|
| Central Line | ☐YES ☐ NO | ☐YES ☐ NO |
| Urinary Catheter | ☐YES ☐ NO | ☐YES ☐ NO |
| Tracheostomy | ☐YES ☐ NO | ☐YES ☐ NO |
| Peripheral Line | ☐YES ☐ NO | ☐YES ☐ NO |
| ET Tube | ☐YES ☐ NO | ☐YES ☐ NO |
| Other …….. | ☐YES ☐ NO | ☐YES ☐ NO |

| | | |
|---|---|---|
| …….. | □YES □ NO | □YES □ NO |
| ……. | □YES □ NO | □YES □ NO |

| Clinical Syndrome | | Present | If yes, infection prevention, precaution / isolation |
|---|---|---|---|
| Open wound with discharge | | Yes No | |
| Diarrhoea | | Yes No | |
| Fever with upper respiratory tract symptoms | Covid positive | Yes No | |
| | Covid negative | Yes No | |
| Fever with rash(infective) | | Yes No | |
| Evidence of suspected tuberculosis (TB)- clinically / Radiologically | | Yes No | |

| Isolate and contact infection control nurse for advice |
|---|

**RESULT OF PREVIOUS INVESTIGATIONS DONE**

**Assessment for Special Populations:** (Tick the applicable special population and then / encircle the relevant assessment)

If Elderly 65 years old, BMI.....[BMI = Weight in Kg / (Height in m )$^2$]

If BMI < 16, initiate assessment for Frail Elderly

| ☐ **For Frail Elderly Patients** | | | |
|---|---|---|---|
| **Mental Status** | ☐ **WNL** | ☐ **Dementia** | ☐ **Delirium** |
| **H/o Hearing impairment** | ☐ **Yes** | ☐ **No** | |
| **H/o Vision impairment** | ☐ **Yes** | ☐ **No** | |
| **Bowel** | ☐ **Constipation** | ☐ **Continent** | ☐ **Incontinent** |
| **Bladder** | ☐ **Catheter** | ☐ **Continent** | ☐ **Incontinent** |
| **Social support** | ☐ **Alone** | ☐ **Spouse** | ☐ **Other** |
| **Ability to perform activities Of daily life** | ☐ **Dependent** | ☐ **Independent** | |

| |
|---|
| ☐ For Patients with intense pain (pain score > 7) or chronic pain (pain duration of more than 6 weeks) |
| Pain Score 'Now' _____ |
| Pain Score at 'its worst' over the last 24 hrs _____ |
| Location of pain _____ |
| Radiating towards _____ |
| Characteristics of pain<br>☐ Sharp ☐ Dull ☐ Shooting ☐ Spasmodic<br><br>☐ Throbbing ☐ Stabbing ☐ Burning |
| Aggravating factors _____ Relieving factors _____ |
| Pain interferes with - ☐ General activity ☐ Walking ☐ Mood<br>☐ Sleep ☐ Enjoyment of Life |
| Interventions taken ☐ Pharmacological ☐ Non – Pharmacological |

| |
|---|
| ☐ For immunocompromised patients (Suspected by History & Physics assessment or informed by patient / Consultant |
| History of recurrent infection / unexplained fever ☐ ☐ No ☐ Yes, _____ |
| History of chronic wound discharge/non – healing ulcers ☐ ☐ No ☐ Yes, _____ |
| Patient on steroids or immunosuppressive drugs ☐ No ☐ Yes, _____ |
| Potential ports of entry of infection present<br>☐ CAPD Catheter ☐ Chemo Port ☐ Permcath ☐ Urinary Catheter<br>☐ Endotracheal or Tracheostomy tube ☐ Any other<br><br>Any Signs of Infection<br>☐ Fever ☐ Rigors ☐ Hypotension ☐ Tachycardia ☐ Tachypnoea |

| |
|---|
| ☐ For infectious and Communicable disease patients |
| Special precautions required ☐ Yes ☐ No |
| *If yes, special precautions Communicated to Nursing staff ☐ Yes ☐ No |

☐ **For Terminally ill patients**

**Pain management required** ☐**Yes** ☐**No**

**Palliative Care referral needed** ☐ ☐**Yes** ☐ **No**

**DVT prophylaxis measures** ☐**Yes** ☐**No**

**Bereavement support required** ☐ ☐ **Yes*** ☐ ☐

**No Religious/Cultural/Spiritual requirements** ☐ **Yes*** ☐**No**

*If Yes, Give referral to Medical Social worker

☐ **For victims of abuse and neglect**

**Altered emotional behaviour i.e. Signs of anger / fear / depression** ☐**Yes** ☐**No**

**Presence of burns** ☐**Yes** ☐**No**

**Bite marks presence** ☐**Yes** ☐**No**

**Any fracture dislocations** ☐**Yes** ☐**No**

**Post – traumatic stress disorder** ☐**Yes** ☐**No**

**Attention deficit hyperactivity disorder** ☐ ☐**Yes** ☐ **No**

**Sleep disorders** ☐**Yes** ☐**No**

**Social support / Lives** ☐**Alone** ☐**Spouse** ☐**Others**

**FUNCTIONAL STATUS** ☐**Dependent** ☐**Independent**

**NUTRITIONAL ASSESSMENT** (Encircle the finding for each Criteria and add up the score)

| CRITERIA | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| Decreased food intake over last 3 months | Severe Loss | Moderate Loss | - | No Loss |
| Weight Loss in last 3 months | >3 Kg | Do not Know | 1 to 3 Kg | No Loss |

| | | | | |
|---|---|---|---|---|
| Mobility at the time of admission | Bed/Chair bound | Able to but does not | Fully Mobile | - |
| Acute disease in last 3 months | Yes | - | No | - |
| Neuropsychological problem | Severe dementia | Mild dementia | None | - |
| Body Habitus | Cachectic / Morbid | Obese | Thin | Average |
| **Total Score - ____; Normal diet if > 11, Dietary referral needed if ≤ 11.** | | | | |

## DISCHARGE PLANNING AND SPECIAL EDUCATION NEEDS & PLAN

**Social support needed at home** ☐**No** ☐**Yes; Patient and Family Education done**

**Home equipment anticipated** ☐**No** ☐**Yes; Patient and Family. Education done and equipment. advised**

**Physiotherapy at home anticipated**☐ ☐**No** □ **Yes; Educated on physical limitations (if any)**

**Wound care needs anticipated at home** □ **No** ☐**Yes; Educated on signs of infection**

**Pain management** ☐**No** ☐**Yes; Patient and Family. Education done and medication advised**

**Special dietary needs** ☐**No** ☐**Yes; Educated on dietary restrictions, food drug interactions and allergies**

**Continuous / Ongoing care anticipated**☐ ☐**No** □ **Yes; Educated on ongoing care requirements**

**Other special education needs** ☐**No** ☐**Yes; Patient and Family Education done on special need**

**……**

Nature of post hospital care needs (patient safety/infection control/ Fall risk, etc.)

| # | Diagnosis/ Provisional Diagnosis | Assessments / Plan of care |
|---|---|---|

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**EXPECTED OUTCOME AT DISCHARGE (as applicable)**

☐ **Vital Stable**

☐ **Diet – Normal / Supplemental; specify**

☐ **Pain score below _____ / 10**

☐ **Ambulatory – Yes / No**

☐ **Blood Sugar levels; Controlled**

☐ **Surgical wound clean**

| | |
|---|---|
| **Nutrition Status** | **Dietary referral yes no** |
| **Terminally ill patients** | **Medical Social worker referral yes no** |
| **Physiotherapy assessment** | **Physiotherapy referral needed yes no** |

**Signature of Junior Medical Staff / Name / Date / Time:**

**Consultant Sign.**

## Disclaimer

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