2704

PROVIDENCE Health & Services

OREGON REGION

ADULT HEALTH STATUS SUMMARY

 PATIENT LABEL

THIS PAGE TO BE COMPLETED BY NURSE

PRE-SURGICAL SERVICES (SURGICAL SERVICES ONLY)

Date: _____ ❑ Telephone ❑ Visit Vital Signs: _____

VITAL SIGNS (OUTPATIENT SURGERY ONLY)

T _____ P _____ R _____ BP(L) _____ BP(R) _____ O2Sat _____ % on _____ Ht _____ Wt _____ lbs/kgs BMI _____

ADMIT / TRANSFER NOTE

Arrival Date: _____ **Arrival Time:** _____ **Unit / Room #:** _____
Arrival From: _____
Arrival Mode: ❑ Walk-in ❑ Stretcher ❑ Bed ❑ WC ❑ Carried ❑ Ambulance ❑ Air ambulance ❑ Police ❑ Secure transport
Preferred Language For Discussing Health Care: ❑ English ❑ Spanish Other: _____
Why are you here? _____

CONTACTS

Primary Contact: _____ Relationship: _____
Phone #1: _____ Phone #2: _____
Secondary Contact: _____ Relationship: _____
Phone #1: _____ Phone #2: _____

ADVANCE DIRECTIVE

❑ No ❑ Info given ❑ Info declined ❑ No – pt under 18 ❑ In chart ❑ Get from old chart
❑ SO to bring ❑ Req from contact ❑ Req from provider ❑ Req other facility ❑ Req from attorney ❑ Pastoral care consult
Other: _____ POLST(Physician Order for Life-Sustaining Treatment)? ❑ No ❑ Yes

HISTORY STATUS

Deferred: ❑ Critical Status ❑ Mental status ❑ No historian **Status:** ❑ Attempted ❑ Partial ❑ Pt. declined

PERSONAL SAFETY

YES	NO	Because violence in the home is a serious risk, we ask everyone
❑	❑	1. Are you here today due to injury or illness related to partner violence?
❑	❑	2. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?
❑	❑	3. Do you feel unsafe in your current relationship?
❑	❑	4. Is there a partner from a previous relationship who is making you feel unsafe now?

NUTRITION SCREENING (REQUIRED FOR INPATIENT ADMISSIONS ONLY)

❑ No identified problem ❑ Unable to assess ❑ Special diet ❑ Supplements ❑ Swallow / aspiration risk
❑ Chewing problems ❑ Wt loss > 13 lb in 1- 3 mos. ❑ Poor intake ❑ Nutrition-related illness ❑ Other: _____

FUNCTIONAL STATUS SCREENING (REQUIRED FOR INPATIENT ADMISSIONS ONLY)

Activities of Daily Living: ❑ INDEPENDENT ❑ Unable to assess
❑ Assist w/ hygiene ❑ Assist w/ bathing ❑ Assist w/ toileting ❑ Assist w/ incontinence ❑ Assist w/ dressing
❑ Assist w/ cooking ❑ Bath bench ❑ Grab bars ❑ Raised toilet seat ❑ Incontinence pads ❑ Commode
Other: _____

Mobility: ❑ INDEPENDENT ❑ Unable to assess
❑ Fall ❑ Walks w/ assist ❑ Walks w/ cane ❑ Walks w/ walker ❑ Walks w/ crutches ❑ Wheelchair independent
❑ Wheelchair w/ assist ❑ Power Wheelchair ❑ Transfers w/ assist ❑ Toilet transfer w/ assist ❑ Stairs w/ assist
❑ Stairs unable ❑ Bedbound ❑ Hospital bed ❑ Mechanical lift
Other: _____

Cognitive: ❑ INDEPENDENT ❑ Unable to assess
❑ Difficulty speaking ❑ Difficulty writing ❑ Difficulty reading ❑ Memory difficulty ❑ TTY/TDD ❑ Communication board
Other: _____

Meds & Treatment Mgmt: ❑ INDEPENDENT ❑ Unable to assess
❑ Dependent ❑ Assist w/ pillbox ❑ Assist w/ syringes ❑ Assist w/ wound care
❑ Assist w/ Ostomy care ❑ Assist w/ home CAPD ❑ Assist w/ tube drain care ❑ Assist w/ tube feedings
❑ Assist w/ IV care ❑ Assist w/ trach care
Other: _____

SUPPORT (REQUIRED FOR INPATIENT ADMISSIONS ONLY)

Cultural traditions impacting care? ❑ No ❑ Yes Describe: _____
Spiritual practices impacting care? ❑ No ❑ Yes Describe: _____
Personal concerns: ❑ None ❑ Care for others ❑ Overly fearful ❑ Overly anxious ❑ Recent loss
❑ Inadequate support structure ❑ No local support ❑ Other: _____
Emergency services: ❑ Able to contact ❑ Unable to contact ❑ Not available

INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME

TARGETED REVIEW when current admission < 30 days since last admission

DATE / SIGNATURE	DATE / SIGNATURE	DATE / SIGNATURE

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INFORMATION SOURCE: PATIENT / RESPONSIBLE PERSON SIGNATURE — **USE PEN TO COMPLETE FORM**

❑ Patient ❑ Other / Relationship _____

Signature: _____

WHEN DID YOU LAST EAT OR DRINK? _____

MEDICAL AND SURGICAL HISTORY

YES	NO		
❑	❑	**Have you been in the hospital in the last 30 days? If yes, why?** _____	
❑	❑	**Surgeries / Procedures / Births (list):**	**DATE**
❑	❑	**Prostheses / Implants (list – for example, Total Joint, AICD, Pacemaker, etc.):**	**DATE**

ANESTHESIA/TRANSFUSION HISTORY

❑	❑	I have had problems with previous ANESTHESIA: ❑ High fever ❑ Muscle weakness
❑	❑	I have a relative who has had problems with ANESTHESIA: ❑ High fever ❑ Muscle weakness
❑	❑	Previous blood transfusion?
❑	❑	Transfusion reaction?
❑	❑	I have an objection to blood transfusions: ❑ Religious objection ❑ Personal objection

SUBSTANCE USE	Denies	Uses	How Much / Often?	Date Last Use?	SUBSTANCE USE	Denies	Uses	How Much / Often?	Date Last Use?
Tobacco use in last 12 months				Quit Date	Meth / Amphetamines				Quit Date
Alcohol					Heroin				
Marijuana					IV Substance				
Cocaine					Other				

ADDITIONAL NARRATIVE NOTES

INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME

If questions about completing this form, please call:

PSVMC 503-216-1993
PPMC 503-215-1874
PMH 503-513-8843
PNMC 503-537-1450
PHRMH 541-386-3911
PMMC 541-732-5537
PSH 503-717-7239
PWFMC 503-650-6845

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YES	NO	Do you have or have you ever had:				
		Cancer:	Type: _____	How long ago? _____		
		Chronic Pain:	Chronic Pain History:			
		Neurological:	❑ Seizures	❑ Stroke	❑ TIA	❑ Numb areas
			❑ ALS	❑ Alzheimers	❑ Guillain-Barré	❑ Fainting	❑ Dizzy spells
			❑ Migraines	❑ Multiple sclerosis	❑ Myasthenia gravis	❑ Weakness	❑ Confusion
			❑ Parkinson's	❑ Head injury	❑ Spinal cord injury	❑ Paralysis	
		EENT:	❑ Cataracts	❑ Glaucoma	❑ Impaired vision	❑ Blind	❑ Dental bridges
			❑ Lens implants	❑ Glasses	❑ Contacts	❑ Artificial eye	❑ Dental caps	❑ Deaf
			❑ Impaired hearing	❑ Hearing aids	❑ Loose teeth	❑ Electrolarynx	❑ Dentures	
		Musculoskeletal:	❑ Back pain	❑ Arthritis	❑ Broken facial bones	❑ TMJ
			❑ Broken neck	❑ Broken pelvis	❑ Degenerative disease	❑ Broken back	
			❑ Cerebral palsy	❑ Fibromyalgia	❑ Muscular dystrophy	❑ Limited range of motion	
		Cardiovascular:	❑ Chest pain	❑ Heart attack	❑ High blood pressure
			❑ Blood clots	❑ Congenital defects	❑ Coronary artery disease	❑ Congestive heart failure
			❑ Murmur	❑ Defibrillator	❑ Pacemaker	❑ Irregular heart beat
			❑ Palpitations	❑ Mitral valve prolapse	❑ Peripheral vascular disease	
		Respiratory:	❑ Chronic bronchitis	❑ Chronic cough	❑ Sleep apnea
			❑ Asthma	❑ Tuberculosis	❑ Pneumonia	❑ Shortness of breath
			❑ Emphysema	❑ Upper resp. infection	❑ Chronic obstructive pulmonary disease	
		Gastrointestinal:	❑ GERD	❑ Diverticulitis	❑ Hiatal hernia	❑ Irritable bowel
			❑ Cirrhosis	❑ Ulcers	❑ Ostomy	❑ Intestinal bleeding	❑ Gall bladder disease
			❑ Hemorrhoids	❑ Hepatitis	❑ Pancreatitis	❑ Hyperemesis	❑ Inflammatory bowel
			❑ Frequent diarrhea	❑ Frequent constipation		❑ Jaundice	
		Renal / Urinary:	❑ Dialysis	❑ Kidney disease	❑ Incontinence
			❑ Frequent urinary tract infection	❑ Urostomy	
		Skin: ❑ Psoriasis	❑ Eczema	❑ Bruises easily	❑ Ulcer / wound
		Immune: ❑ Immune compromised		❑ HIV/AIDs	
		Reproductive:	❑ Child birth	❑ GYN problems	❑ Prostate problems	❑ STIs
		Pregnant? ❑ No ❑ Yes Est Gest Age: _____ wks			Last menstrual period _____	
		Birth control method: _____			Lactating? ❑ No ❑ Yes	
		Behavioral Health:	❑ ADHD	❑ Depression	❑ Bipolar disorder	❑ Obsessive compulsion disorder
			❑ Eating disorder	❑ Panic attacks	❑ Psychotic disorder	❑ Anxiety disorder	❑ Dementia
		Anemia / Bleeding:	❑ Anemia	❑ Bleeding disorder	❑ Sickle cell anemia
		Endocrine:	❑ Diabetes - insulin dependent	❑ Diabetes - oral agent	❑ Diabetes - diet controlled
			❑ Hyperthyroid	❑ Hypothyroid	

Other history: _____

_____

DISCHARGE PLANNING (OUT-PATIENT SETTINGS)

Discharge Transportation Provider:

❑ Same as Contact Person (page 1)

❑ Needs to be called when patient is ready to go home

❑ Will remain here at the hospital

❑ Is planning to return at: _____ (time)

Name: _____

Phone #1: _____ Phone #2: _____

INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME	INITIALS	STAFF SIGNATURE/TITLE	DATE/TIME