PLAN TO ADDRESS PAIN:

- Initiate pain management on plan of care.

If you are not the admitting RN but are adding information, INITIAL and DATE your entries.
### Smoking Cessation Screen:

- **Does the patient ever smoke?**
  - NO
  - YES

- **How many cigarettes did you smoke per day?**
  - Number:

- **Home patient?**
  - NO
  - YES

- **Do you quit smoking?**
  - NO
  - YES

- **If YES, how many weeks?**

### Smoking Cessation Plan:

- **Reviewed Smoking Cessation Pamphlet with patient.**
- **Collaborate with physician for smoking intervention.**

### Nutritional Screen:

- **Chronic Wound/Pressure Ulcer**
  - NO
  - YES

- **Enteral or Parenteral Nutrition feeding**
  - NO
  - YES

- **Food Allergies**
  - NO
  - YES

- **Renal Failure, Liver Failure, New/Untreated Diabetes**
  - NO
  - YES

- **Difficulty Swallowing or Chewing (including denture problems)**
  - NO
  - YES

- **NPO greater than 3 days**
  - NO
  - YES

- **Unintentional Weight Loss**
  - NO
  - YES

- **Patient or family requests to see dietician**
  - NO
  - YES

### Nutritional Plan:

- **Refer to dietician.**
- **Other: **

### Values/Beliefs Screen:

- **Cultural/Ethnic Considerations**
  - NO
  - YES

- **Religious Beliefs**
  - NO
  - YES

- **Pastoral Care**
  - NO
  - YES

### Values/Beliefs Plan:

- **Refer to pastoral care.**
- **Other: **
### COGNITIVE/PERCEPTION SCREEN:

<table>
<thead>
<tr>
<th>Vision:</th>
<th>NO</th>
<th>YES</th>
<th>EXPLANATION/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you having a problem with your vision?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have trouble reading?</td>
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<tr>
<td>Do you wear:</td>
<td></td>
<td></td>
<td>If yes,  with patient  home</td>
</tr>
<tr>
<td>glasses,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>contacts,</td>
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<td></td>
<td></td>
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<tr>
<td>prosthetic eye?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing:</th>
<th>NO</th>
<th>YES</th>
<th>EXPLANATION/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you having problems with your hearing?</td>
<td></td>
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</tr>
<tr>
<td>Do you wear a hearing aid?</td>
<td></td>
<td></td>
<td>If yes,  with patient  home</td>
</tr>
<tr>
<td>Is the patient deaf?</td>
<td></td>
<td></td>
<td>If yes, what level of interpreter do you require?</td>
</tr>
<tr>
<td>Do you use a TDD (phone)?</td>
<td></td>
<td></td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speech:</th>
<th>NO</th>
<th>YES</th>
<th>EXPLANATION/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you having any speech problems (including problems with dentures or dental appliances)?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Do you need an interpreter?</td>
<td></td>
<td></td>
<td>If yes, primary language: ________________________</td>
</tr>
<tr>
<td>Will you need a special way to communicate with nursing staff (I.E. Modified call light)?</td>
<td></td>
<td></td>
<td>Method: ________________________</td>
</tr>
</tbody>
</table>

### PLAN TO ADDRESS COGNITIVE/PERCEPTION PROBLEM(S):

**Vision:**
- Post decreased vision sign.
- Announce self when entering room.
- Use direct eye contact.
- Post Hard of Hearing Sign.
- Write information down.
- TDD 1-800-571-4347
- Sign Language, contact House Manager / Nursing Supervisor.
- Refer to Communication Services Hearing Impaired and Foreign Languages Policy.

**Speech:**
- Provide communication aid:
- alpha/communication board
- modified call light
- other: ________________________
- Request dentures/dental appliance from family.
- Contact Respiratory Therapy for patient who has a tracheostomy.
- AT&T Language Line 1-800-752-6096 or 1-800-874-9426
- HFH ID# 208026 + unit cost center or HFW ID# 122700
- Other: ________________________

### EDUCATION SCREEN:

**What do you need to know to take care of yourself before discharge?**

**How do you learn best?**
- Reading
- Hands-On
- Demonstration
- Video

**When do you learn best?**
- Morning
- Afternoon
- Evening

**Do you feel that you have special learning needs?**
- NO
- YES, explain:

**Is there anyone else that you would like to be included in your health education?**

**Where do you get your health information?**

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PLEASE NOTE: DUE TO MANUFACTURING REQUIREMENTS THE BACKER SHOWS UPSIDE-DOWN ON PROOF. IT WILL PRINT WITH THE CORRECT ORIENTATION.

PROOF PDF

FUNCTIONAL SCREEN:

- Do you have a problem that keeps you from performing tasks that you were able to do in the past?
  - If yes, state problem: ________________________
  - Is the problem new? NO YES

- Do you have a problem that interferes with the way that you walk, your balance, or how far or long you are able to walk?
  - If yes, state problem: ________________________
  - Is the problem new? NO YES

- Do you use a mobility device at home?
  - If yes, what: Wheelchair, Cane, Walker, Wheeled Walker, Other: ________________________
  - Where are they? at home, with patient, at hospital, at home, elsewhere

- Do you need assistance with:
  - Bathing
  - Dressing
  - Eating
  - Walking
  - Preparing Meals
  - Medication
  - Treatment

- Does patient have a small frame, slight build, is sedated/restless, or lacks muscle control?
- Does patient have a problem sleeping?
  - If yes, what helps? __________________________
- Do you use sleep aids?
  - If yes, what? ______________________________
- When do you normally sleep? Day Evening Night

PLAN TO ADDRESS FUNCTIONAL ASSESSMENT:

- Fall assessment completed. (See flowsheet)
- Other: __________________________________________
- Obtain from Central Equipment:
  - Mobility Device used at home.
  - Side Rail Pads to prevent Bed Entrapment
- Patient in bed, not requiring side rail pads.
- Collaborate with Physician for: Rehabilitation Therapy consultation.
- Include sleep interventions in nursing plan of care.
- Bed Rail pads

DISCHARGE PLANNING SCREEN:

- Is the patient over 70 years old? NO YES
- Is the patient homeless? NO YES
- Were you living in a Nursing Home, Assisted Living, Rehabilitation Center, or Foster Care before you were admitted? NO YES
- Do you live alone? NO YES
- Do you live with someone who provides care for you? YES NO
- Is the patient homeless? NO YES
- Is the patient over 70 years old? NO YES

If YES, refer immediately to Case Management.

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### ADDITIONAL ADMISSION ITEMS FOR PEDIATRIC PATIENTS (age 17 years and under)

#### PEDIATRIC VISITATION:
- The patient's legal guardian has completed the Approved Visitors List (see below).

<table>
<thead>
<tr>
<th>APPROVED VISITORS LIST</th>
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<tbody>
<tr>
<td><strong>NAME OF VISITOR</strong></td>
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<tr>
<td><strong>RELATIONSHIP TO PATIENT</strong></td>
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<tr>
<td>1.</td>
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<td>3.</td>
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- Visitation Policy reviewed with Legal Guardian and Patient (as appropriate)

Include the following items:
- Up to four (4) family members and/or visitors can be listed on the Approved Visitor List. Only these people may visit the patient in the absence of the Legal Guardian.
- For safety reasons, Nursing Staff will request to see valid photo identification of all individual's requesting to visit patient.
- Individuals not listed on the Approved Visitors List, will not be permitted to visit in the absence of the patient’s legal guardian. These individuals will be directed to the Family Waiting area.
- All visitors must check in and be cleared for visitation prior to entering the patient care area.
- One visitor may stay overnight with prior parental approval.
- Only two visitors will be allowed in the room at one time.

*For the ICU's, OR, ER, Maternal Child areas only:*
- Cell phone use is prohibited in the patient care area.
- No food, drinks or live plants/flowers may be brought into the room.

#### PEDIATRIC DISCHARGE DISPOSITION:

This patient may be discharged home with the following person(s) only:

<table>
<thead>
<tr>
<th>NAME OF VISITOR</th>
<th>RELATIONSHIP</th>
<th>CONTACT NUMBER</th>
</tr>
</thead>
</table>

#### PEDIATRIC INFORMED CONSENT

- Minor† of any age may consent for:
  - Substance Abuse Treatment
  - Treatment for Venereal Disease, HIV, or AIDS*
  - Prenatal and pregnancy related care for the health care of the minor
- Minor† 14 years of age and older may consent for
  - A series of up to twelve (12) outpatient visits for mental health services
  - An inpatient stay for mental health services if deemed 'suitable'

†For further clarification regarding consenting ability by minors, please refer to policy: Consent to Medical and Surgical Treatment and Informed Consent Policy (#430.40) or consult with Medical Legal and/or Corporate Legal Affairs.

*The presence of venereal disease in a child who is less than twelve (12) years of age requires a child abuse petition to be filed with Michigan Protective Services.

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<table>
<thead>
<tr>
<th>Signature/Title</th>
<th>Date/Time</th>
<th>Initials</th>
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Unable to complete Admission Database because ______________________________________________________

______________________________________________________Date:  ________  Time:  ________  Initials: _____

Unable to complete Admission Database because ______________________________________________________

______________________________________________________Date:  ________  Time:  ________  Initials: _____

Unable to complete Admission Database because ______________________________________________________

______________________________________________________Date:  ________  Time:  ________  Initials: _____

Unable to complete Admission Database because ______________________________________________________

______________________________________________________Date:  ________  Time:  ________  Initials: _____

**SIGNATURES/INITIALS**

Additional Comments