CVH-519 **CONNECTICUT VALLEY HOSPITAL**
New 5/18 **ADMISSION NURSING ASSESSMENT** Name: _____

Addiction Services Division MPI #: _____ *Print or Addressograph Imprint*

Date of Admission: _____ Patient's Preferred Language: _____

DIMENSION I – ACUTE INTOXICATION AND/OR WITHDRAWAL

***A. SUBSTANCE ABUSE/CURRENT USE PATTERNS – WITHDRAWAL POTENTIAL**

Substance	Amount, Frequency, Route	Duration of Use	Date/Time Last Intake	
Check those that apply: ☐ Alcohol ☐ Heroin ☐ Cocaine ☐ Marijuana ☐ Amphetamines ☐ Others (*list*): _____ _____ _____ _____ _____				**Comment on life consequences due to dependence:** _____ _____ _____ _____ _____ _____ _____ _____

Last Blood Alcohol Level _____ Date _____ Time _____

B. Complications [ ] No evidence at this time

Complications - *Circle all that apply*:	Date of Last Occurrence	Comments
• Blackouts		
• D.T.'s		
• Withdrawal Seizures		
• Paranoia/Psychosis		
• Depressed Mood		
• Other: _____		

C. Identify the Patients strengths related to abstinence/sobriety (*Circle all that apply*):

STRENGTHS

- Familiar with self-help/12 Steps
- Voluntary Admission
- Requesting Treatment
- Has Sponsor
- Past/Recent Period(s) of Sobriety
- Family Support
- Employer Support
- Cognitively Sound
- Desires Rehab Program
- Motivation to Succeed in Treatment
- Other: _____
  _____
  _____
  _____
  _____

***D. CURRENT MEDICATION** Medications taken by the patient prior to admission (prescription medications, over-the-counter medications and herbal preparations) are recorded on the Admission Medication List and Verification Form (Medication Reconciliation) CVH-581a and continuation form CVH-581b.

Patient Name: _____ MPI#: _____ *Print or Addressograph Imprint*

DIMENSION II – MEDICAL CONDITIONS

Height _____ Weight _____ Blood Pressure _____

Temperature_____ Pulse _____ Respirations _____

Allergies to Medications: _____

Allergies to Food: _____

***BIOPHYSICAL ASSESSMENT:** (*current or history of*)

A. Existing Medical Problems (*Circle all that apply*):

		Comments
• Diabetes • Cardiac Disease • Arthritis • Hypertension • CVA • Head Trauma	• COPD • Cancer • Renal • History of Seizures • Other: _____	

***B. Assessment of Pain: [ ] No report of pain at this time** **If the patient reports pain, complete as indicated.**

Current or History of Pain (*Please Specify*): _____

FLACC Pain Scale: **If the patient is non-verbal and unable to provide information about pain, Please complete the FLACC Scale (Face, Legs, Activity, Cry and Consolability) to assess pain.**

Severity: ☐(*1-10*): _____ *OR*

Location: _____ ☐ FLACC Score: _____ **Onset**: _____

Duration: ☐ Acute Pain (*Few seconds to less than 6 months*) ☐ Chronic Pain (*Greater than 6 months*)

***Circle all that apply*:**

Type of Pain	**Quality of Pain:**
• Cutaneous (*Sensation*)	• Sharp
• Somatic (*Tendons, Ligaments, Bones, Blood Vessels, Nerves*)	• Dull
• Visceral (*Organs*)	• Diffuse
• Referred	• Shifting
• Neuropathic (*Functional pain*)	• Burning

Aggravating Factors (*Circumstances which cause pain to return or escalate*): _____

Alleviating Factors (*Techniques or circumstances that reduce or relieve the pain*): _____

Effect on Level of Functioning (*Sleep, Changes in Mood, Appetite, Work, Exercise, ADL's, Relations*): _____

Current Treatments	**Effectiveness** (*Relief, Some Benefit, Not Effective):*
• Drug Therapy (*please specify*): _____	_____
• Acupuncture	_____
• Biofeedback	_____
• Relaxation/Meditation/Imagery	_____
• Heat/Cold	_____
• Other: _____	_____

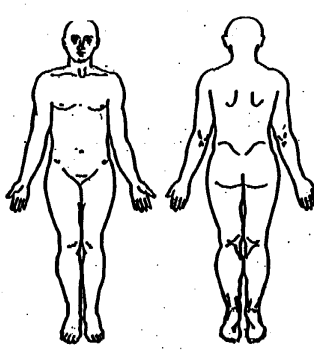
Does pain appear to be associated with substance withdrawal?: ☐ Yes ☐ No ☐ N/A

Does pain appear to be associated with a co-occurring medical issue?: ☐ Yes ☐ No ☐ N/A

If yes, please specify and include nursing specific educational interventions in the Initial Nursing Plan of Care.

Any identified pain issues refer to the ACS Clinician and Psychiatrist.

Patient Name: _____ MPI#: _____ *Print or Addressograph Imprint*

OBSERVATIONS – Circle all applicable observations	**Comments**
C. Identifying Marks/Injuries • None observed • Scars • Cuts • Bruises • Rashes • Tattoos • Sutures • Decubiti • Piercings • Open wounds • Track marks • Discolorations • Other: _____ _____ FRONT  BACK	
D. Nutrition/Metabolic • **No impairments noted** • Weight loss (*last 3 mos.if known*) approx. amount: _____ • Weight gain (*last 3 mos.if known*) approx. amount: _____ • Appearance: o underweight o over weight o malnourished • Cultural habits: _____ _____ Eating habits: o loss of appetite o slow eater o fast eater o refusal to eat • Fluid Intake: o poor o adequate o excessive • Other: _____ _____	

E. Nutrition Screen (*Check all that apply*)

Are any of the following conditions known?

_____ diabetes
_____ renal disease
_____ cancer
_____ AIDS or HIV
_____ eating disorder

Is the patient?

_____ pregnant or breastfeeding
_____ taking MAOI within the last 2 weeks
_____ experiencing symptoms of anorexia or bulimia
_____ receiving dialysis
_____ having chewing or swallowing difficulties
_____ tube feeding
_____ on a special diet or NPO
_____ taking any nutritional supplements or other herbal remedies
_____ experiencing slow healing wounds
_____ food allergies: _____

[ ] No positive results noted in above Nutritional Screen

Any positive response/impairment noted in the Nutritional/Metabolic or Nutritional Screen a Nutritional Consult is ordered: Notify ACS Clinician During Business Hours and the On Call MD for 2nd and 3rd shifts, weekends and holidays.

Notified by: _____ Date and Time: _____

and **Notify Dietary Department (leave voice mail)**

Message left by: _____ Date and Time: _____

F. INFECTIOUS DISEASE SCREEN

Complete Infectious Disease Screen CVH-628

OBSERVATIONS - Circle all applicable observations		**Comments**
G. Prosthetic Devices • None • Glasses • Dentures o full o partial • Hearing aid	• Contact lenses • Artificial limb(s) • Ostomy devices • Pacemaker • Other: _____	
H. Activities of Daily Living 1. **Grooming/Personal** *Indicate* **I = Independent A = Assisted** • Bathing _____ • Showering _____ • Dressing _____ • Shaving _____	• Hair Care _____ • Eating _____ • Toileting _____ • Other: _____	
2. **Mobility/Ambulation** • Full • Partial • Non-ambulatory	*Indicate:* I = Independent A = Assisted • Wheelchair _____ • Walker _____ • Cane _____ • Crutches _____ • Prostheses _____	

I. Fall Risk

Complete Fall Risk Screening CVH-574

Comment on need for assistance/ supervision and environmental safety requirements: _____

OBSERVATIONS - Circle all applicable observations		**Comments**
J. Identify Patient's Biophysical Strengths: **Strengths** • Good health • Without history of medical illness • Well nourished	• Good physical condition • Good appetite • Sleeps well • No known allergies • Self care • Other: _____ • _____	

DIMENSION III – EMOTIONAL BEHAVIORAL CONDITIONS

***** **RISK ASSESSMENT**

A. SELF-HARM AND SUICIDE RISK (*Check the appropriate answer (Y/N) and comment on patients' answers or record patients' response to specific questions.)*

		COMMENTS/PATIENT RESPONSE
1	How does the future look to you?	
2	What things in your life make you want to go on living?	
3	Whom do you rely on during difficult times?	
4	Has treatment been effective for you in the past? [ ] Yes [ ] No [ ] N/A	
5	Are there things that you've been feeling guilty about or blaming yourself for? [ ] Yes [ ] No	
6	Did you ever wish you could go to sleep and just not wake up? [ ] Yes [ ] No	
7	Have you ever felt that life is not worth living? [ ] Yes [ ] No	
8	Do you consider yourself an impulsive person? [ ] Yes [ ] No Why or Why Not?	

		COMMENTS/PATIENT RESPONSE
9	When people are feeling extremely upset, they sometimes have thoughts of wanting to harm themselves. Have you had any thoughts of wanting to harm/hurt yourself? [ ] Yes [ ] No ***If no, proceed to # 12***	
10	If you begin to have thoughts of harming yourself what would you do?	
11	Have you ever acted on these thoughts? [ ] Yes [ ] No *If yes*, please describe:	
12	Have there been times when voices told you to hurt or kill yourself? [ ] Yes [ ] No	
13	Have you ever had thoughts of wanting to kill yourself? [ ] Yes [ ] No ***If no, proceed to # 27***	
14	Can you tell me about the first time you ever thought about suicide?	
	a. What triggered your thinking about suicide?	
	b. Why did you think suicide was the best option at that time?	
	c. Did you want to die? [ ] Yes [ ] No	
	d. Please tell me exactly what you did.	
	e. Were you injured by the suicide attempt? [ ] Yes [ ] No	
	f. Did you receive medical care? [ ] Yes [ ] No	
	g. Did you take steps to prevent your discovery or rescue? [ ] Yes [ ] No	
	h. How do you feel about surviving?	
	i. Did you learn anything helpful about yourself or others? [ ] Yes [ ] No	
15	Have there been other times in your life when you tried to kill yourself? [ ] Yes [ ] No *If yes*, please describe when, where, why and how.	
16	Have you thought about or attempted suicide in the past year? [ ] Yes [ ] No	
17	Have you thought about or attempted suicide in the past month? [ ] Yes [ ] No	
18	How often do you think about killing yourself? (*Check one*) **Frequency:** [ ] Never [ ] Rarely [ ] Sometimes [ ] Frequently [ ] Daily	
19	When you have these thoughts, how intense or severe are they? (*Circle one*) **Intensity:** Mild 1 2 3 4 5 6 7 8 9 10 Severe	
20	Have you thought about when you would kill yourself? [ ] Yes [ ] No	
21	Have you thought about where you would kill yourself? [ ] Yes [ ] No	
22	Have you thought about how? [ ] Yes [ ] No	
23	Do you have access to the means to end your life? [ ] Yes [ ] No *If yes*, please describe:	
24	Have you made any particular preparations? [ ] Yes [ ] No	
25	Have you rehearsed your suicide in any way? [ ] Yes [ ] No	
26	Why do you want to die?	

27	Has anyone in your family attempted suicide? [ ] Yes [ ] No *If yes*, please identify who, when and circumstances:
28	Self Harm and Suicide Risk History:
	• Indication of Self Harm [ ] Yes [ ] No
	• Self Mutilating Behaviors [ ] Yes [ ] No
	• Suicidal Ideation [ ] Yes [ ] No
	• Current Suicidal Intent [ ] Yes [ ] No [ ] Unknown
	• Current Plan [ ] Yes [ ] No [ ] Unknown
	• Single Attempt [ ] Yes [ ] No
	• Multiple Attempts [ ] Yes [ ] No
	• Appears to be withholding information regarding history [ ] Yes [ ] No

Immediately notify the MD if there are any YES responses or new information is obtained regarding the patient's suicide potential which was not elicited during the MD assessment.

MD Contacted: [ ] No
[ ] Yes: _____ _____ _____AM/PM
Physician Name Date Time

Contacted by: _____ _____
RN Signature Print Name

OBSERVATIONS - Circle all applicable observations

B. *Violence Risk:

- No evidence at this time
- Recent history of violence
- Precipitants to anger: _____
- Coping methods used to gain self-control: _____
- Family dysfunction relative to violence
- Physical History
  - o Brain Dysfunction
  - o TBI
  - o Other(s)
- History of Alcohol/Substance Abuse
- Delusions of persecutions present
- High interest in weapons
- Plan for violent acts

Other: _____

How has dependence affected your violent episodes?

_____
_____
_____
_____
_____
_____

C. PERSONAL PREFERENCES

1. What helps when you are not feeling well? (*Check all that apply*)

[ ] Lying down with a cold face cloth
[ ] Additional/extra medication
[ ] Taking a shower or bath
[ ] Exercise
[ ] Sitting by the nurses station
[ ] Calling your therapist
[ ] Calling a friend or family
[ ] Going for a walk
[ ] Wrapping up in a blanket
[ ] A warm or cool drink
[ ] Reading
[ ] Drawing
[ ] Watching TV
[ ] Talking with another patient
[ ] Pacing the halls
[ ] Other, specify below
[ ] Deep breathing
[ ] Eating something
[ ] Writing in a diary/journal/letter
[ ] Playing a game
[ ] Talking to staff
[ ] Talking with chaplain
[ ] Listening to music

Elaborate on above choices as needed: _____
_____

2. What are some things that make it more difficult for you when you are already upset? (*Check all that apply*)

[ ] Being touched
[ ] Not having input/choices
[ ] Being isolated/alone
[ ] Noise in general
[ ] Not being able to express my opinion
[ ] Lack of attention
[ ] Loud noise
[ ] Particular time of day
[ ] People staring at me
[ ] Being criticized
[ ] Boredom/lack of activities
[ ] Yelling
[ ] Time of year

Elaborate on above choices as needed: _____
_____

Patient Name: _____ MPI#: _____ *Print or Addressograph Imprint*

OBSERVATIONS - Circle all applicable observations

D. VICTIMIZATION RISK

- None indicated at this time
- Prior to admission, person was victimized: o verbally o physically
- Sexually: o rape o incest o other: _____
- Help sought from: _____
  - o help effective
  - o help ineffective
- Presence of bruises, abrasions, cuts, etc.
- History of Post Traumatic Stress Disorder
- History of being abused:
  - o as a child
  - o as an adult
- Type of abuse:
  - o verbal
  - o physical
  - o sexual
  - o rape
  - o incest
  - o other: _____

How has dependence impacted your trauma experience?

_____

_____

_____

_____

_____

_____

_____

_____

***MENTAL HEALTH ASSESSMENT**

OBSERVATIONS - Circle all applicable observations **Comments**

A. General Appearance (*posture, grooming, attire, etc.*):

- Appropriate to situation
- Disheveled
- Eccentric

B. Affect

- Labile
- Flat
- Cheerful
- Appropriate to situation
- Other: _____

C. Cognition

- Oriented
- Alert

Memory

- Able to Concentrate
- Attentive

D. Attitude

- Cooperative
- Hostile
- Defensive
- Guarded
- Other: _____

E. Sleep/Rest

- No impairments noted
- Number of hours problematic
- Frequent awakening
- Insomnia
- Dreams
- Nightmares
- Terrors
- Sleepwalking
- Naps frequently during the day
- Hypersomnia
- Difficulty falling asleep
- Early morning awakening
- Other: _____

F. Identify the Patient's Mental Health Strengths:

- Ability to concentrate
- Ability to accept redirection
- Ability to articulate clearly
- Motivated toward successful treatment Assertive
- Ability to collaborate in treatment planning
- Ability to verbalize needs and desires

SUMMARY OF FINDINGS AND INITIAL PLAN OF CARE

A. Patients Expectations of Treatment/Life Goals (in the patient's own words): _____

_____

_____

_____

B. 1. Patient Strengths and Assets to Achieve Goals: _____

_____

_____

_____

2. Patient Barriers to Achieve Goals: _____

_____

_____

_____

C. Initial Nursing Plan of Care:

Nursing care needs/ problems that will be addressed by Nursing Staff immediately and prior to the development of the Initial Master Treatment Plan.

Please include any identified pain issues in the Initial Plan of Care with Nursing interventions that include patient education.

Nursing Care Problem	Intervention(s) and Target Date	Assigned Nursing Staff

D. Registered Nurse Signatures:

1. Signature of Initial Assessing Registered Nurse	Initials	Date	Time

2. Signature of Subsequent Assessing Registered Nurse(s)	Initials	Date	Time