BAYLOR HEALTH CARE SYSTEM

OUTPATIENT ASSESSMENT QUESTIONNAIRE
RADIOLOGY DEPARTMENT

Patient Information and History:

First Name: ______________ Last: ____________ Date of Birth: _________ Age: _____ Height: _____ Weight: _____

What can we do to make sure you receive very good care? ____

Do you have someone with you today? ☐ Yes ☐ No If yes, Name: ______________ Cell phone number: _________

Reason you are having this exam: ____

____

Do you have a history of cancer? ☐ Yes ☐ No If yes, what type: _________________________________

Did the treatment include: Radiation therapy? ☐ Yes ☐ No If yes, what part of body: ___________________
Chemotherapy? ☐ Yes ☐ No

List any previous surgeries and date of surgery:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Have you had any previous scans of the same area we are scanning today? If so, please list.

Exam Type: ______________________________ Where: ____________________ When: __________________

Exam Type: ______________________________ Where: ____________________ When: __________________

Exam Type: ______________________________ Where: ____________________ When: __________________

Exam Type: ______________________________ Where: ____________________ When: __________________

Exam Type: ______________________________ Where: ____________________ When: __________________

Female Patients:

To be completed for/by all female patients.

Date of Start of Last Menstrual Cycle: __________________

☐ Yes ☐ No ☐ Maybe Are you pregnant?

☐ Yes ☐ No Are you currently breast-feeding?

☐ Yes ☐ No Have you had a tubal ligation (tubes tied)? If yes, Date: _______________

☐ Yes ☐ No Are you using a form of birth control or have had a procedure that completely stops your periods?

☐ Yes ☐ No Have you had a hysterectomy (uterus removed)?

☐ Yes ☐ No ☐ Maybe Are you currently in menopause?

☐ Yes ☐ No Have you completed menopause and have not had a period in the last 2 years?

☐ Yes ☐ No Have you had a medically administered pregnancy test within the last 3 days?

I have read and understood the above information and the information above is correct.

______________________________	______________________________	____________	____________
Printed Name Patient/Legal Representative	Signature Patient/Legal Representative	Date	Time

BAYLOR HEALTH CARE SYSTEM

BHCS-49410 (Rev. 11/11)

OUTPATIENT ASSESSMENT QUESTIONNAIRE
RADIOLOGY DEPARTMENT

BAYLOR HEALTH CARE SYSTEM
PATIENT HISTORY FOR CONTRAST MEDIA

Patient Name:____________________ Date of Birth: __________ Height: ______ Weight: ______

1. ***Please indicate if you have one of the following:***

☐ Yes ☐ No History of "kidney disease" as an adult
☐ Yes ☐ No History of kidney transplant
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Myeloma
☐ Yes ☐ No Lupus
☐ Yes ☐ No Contrast exam performed within the last 7 days?
☐ Yes ☐ No Recent surgeries in the last 2 weeks? If yes, please list: ____________________
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Are you over the age of 60
☐ Yes ☐ No Are you taking Metformin or Metformin-containing drug combinations (Metformin, Avandamet, Glucophage, PrandiMet, Metaglip, Riomet, Janumet, Kombiglyze, Fortamet, Glucovance, Glumetza, Actoplus Met)
☐ Yes ☐ No Regular use of antibiotics, Advil, Aleve or Motrin

2. ☐ **YES** ☐ **NO** **Have you ever had a reaction to contrast** (e.g. iodine, gadolinium or barium)?

If "YES", please describe: ____
If yes, have you been pre-medicated for your exam today? ☐ Yes ☐ No

3. ***Do you have any of the following medical conditions:***

☐ Yes ☐ No Active asthma, bronchospasm or bronchitis requiring treatment
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Currently undergoing Dialysis? If yes, what type: ☐ hemodialysis ☐ peritoneal
☐ Yes ☐ No Fluid restrictions
☐ Yes ☐ No History of allergic (anaphylactic) reaction to one or more allergens

Signed: ____ Date: __________ Time: __________
(Patient, Parent or Guardian)

To be filled out by the technologist performing your exam

IV Performed By: ____________________ IV Gauge: ____________ IV Site: Right / Left Arm / Hand

Creatinine Result: _____ mg/dL Result Date: __________ Estimated GFR: ________ Performed By: ________

Oral Contrast Type: ________________ Amount: _________ Lot #: ____________ Exp: ____________

IV Contrast Type: ________ Amount: ________ Lot #: ________ Exp: _____ Rate: _____ cc/sec PSI: _______

Technologist: ____ Date: __________ Time: __________

Legend: **cc/sec** = cubic centimeter per second, **Exp** = expiration, **GFR** = glomerular filtration rate, **IV** = intravenous, **mg/dL** = milligrams per deciliter
PSI = pound per square inch

BAYLOR HEALTH CARE SYSTEM

BHCS-49045 (Rev. 12/11)

PATIENT HISTORY FOR CONTRAST MEDIA

MEDICATION RECONCILIATION

Allergies:_______________________ ☐ Latex ☐ Tape ☐ Iodine ☐ Contrast Media (Dye) ☐ None

Admit Information Source: ☐ Patient ☐ Caregiver/Family ☐ Other:_______________________

Unable to obtain due to: ☐ Patient condition ☐ Lack of knowledge of meds

(Include all herbals, prescription, and non prescription medications, supplements, eye drops, inhaler, etc...)

Physician Instructions at Discharge				Current Medications Name of Drug and Dose Prior to Hospital Visit	Route of Medication (how you take)	Frequency of Medication (How often do you take?)	Last time med was taken/given (before hospital visit)	
Continue after Hospital Visit		Next Dose Due						
Yes	No	Date	Time				Date	Time

List Completed by (staff member) signature/initials:_______________ Date: __________ Time: __________

RN Updating List signature/initials:_______________ Date: __________ Time: __________

Frequency of Medications (How often do you take?)	Route of Medication (how you take)	Next date and time medications are to be taken	New/Changed Medications given at time of discharge

Physician Signature:_______________ Provider #: __________ Date: __________ Time: __________

Please review any changes made to your medications during this hospital stay. Knowing your medications is important to your health. Please update your list as your medications change and take a copy to your doctors' appointments and hospital visits.

Patient/Responsible Party Signature: _______________ Date : __________ Time: __________

Discharge Nurse Signature: _______________ Date : __________ Time: __________

OUTPATIENT FALL RISK ASSESSMENT

Ask patient and check all appropriate answers:

Fall Risk Assessment

Yes	No	
☐	☐	Do you feel unsteady when you walk?
☐	☐	Do you require assistance to help you walk, ie. wheelchair, cane, walker, etc?
☐	☐	Have you had any recent falls or near falls?
☐	☐	Are you taking any medications that make you drowsy or dizzy? ie. medications, to help you sleep, to calm you, for depression or seizures?
☐	☐	Have you experienced any recent anxiety, confusion, forgetfulness or disorientation?

☐ Patient is at high risk for falls (Check if any answer above is YES)

Fall Prevention/Interventions - Check all appropriate answers:

- ☐ Escorted patient under their own power
- ☐ Escorted patient by wheelchair
- ☐ Instructed patient that a staff member should be present each time they walk
- ☐ Provided patient with educational material
- ☐ Environment free of clutter

Staff Signature: ________________________________ **Date:** _______________ **Time:** ______________

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

53486 (03/12)

OUTPATIENT FALL RISK ASSESSMENT

Letter of Welcome

Dear Patient:

Our goal is to provide very good care in every aspect of your hospital visit. Our staff is committed to working together as a team to coordinate your care, manage your pain, and provide as much information as you want about your care.

We need your help. To improve your recovery and healing, please give us feedback on anything we can do to make you more comfortable during your stay.

While you are at Baylor, please feel free to call on your caregivers for any needs. If your caregivers are unable to answer your questions, please feel free to contact our Nursing Supervisor at 214-820-3013. If the Nursing Supervisor is unable to meet your needs, then do not hesitate to contact me at 214-820-4141. After hours, I may be reached at 214-549-4652.

Baylor strives to be the best place to give and receive safe, quality, compassionate healthcare. Thank you for allowing Baylor the opportunity to serve you.

Sincerely,

John B. McWhorter, III
President

Baylor University Medical Center
Pre-Admission

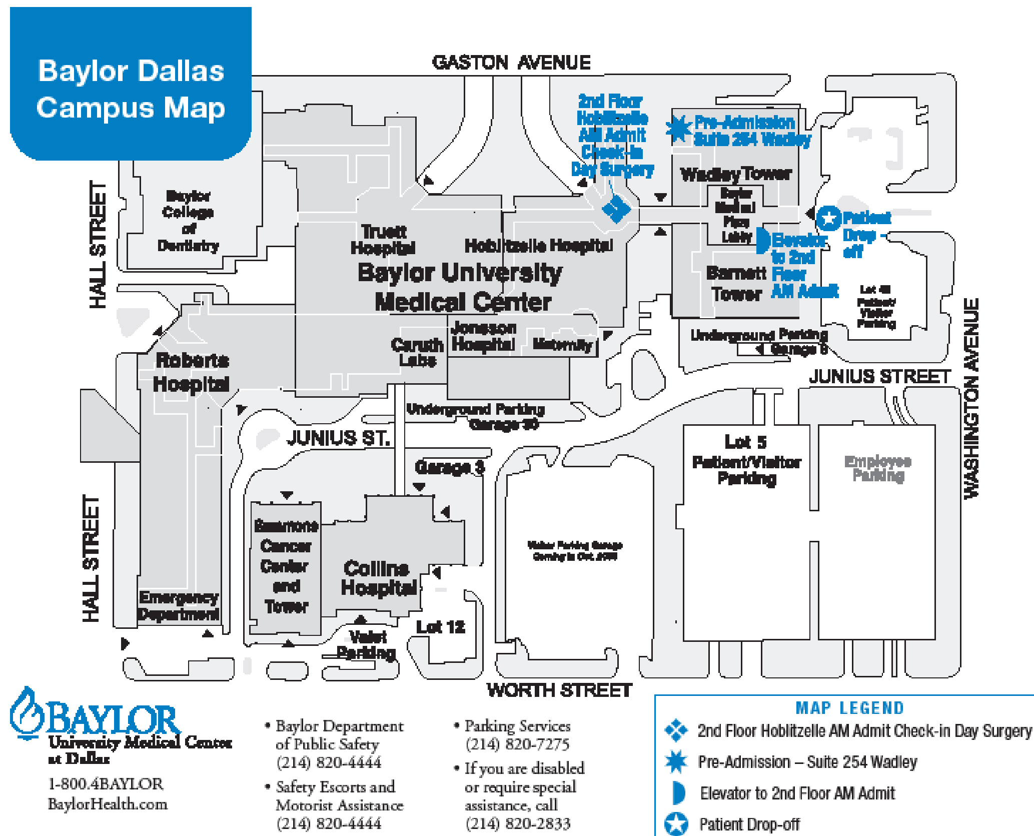
Pre-admission is located on the 2nd floor of Wadley Tower, Suite 254. Pre-admission is the process to complete all the paperwork and testing prior to the day of surgery. The test results (Labs, EKG, and Chest XRAY) will be sent to your physician's office for review**. If you have had recent tests elsewhere, please either bring those results with you or send them to your physician, as it may not be necessary to repeat them if they are current.** Please bring your driver's license or some other federally issued photo I.D. as this is the name we will use for your records. In addition, please bring a list of your current medications and any supplements you take.

Office Hours for Pre-admission are:
Monday – Friday 8 a.m. – 5 p.m.
Pre-admission is closed weekends and holidays

Please call for all appointment to pre-admit at least 3 days prior to your scheduled surgery date. Appointments can either be in person or by telephone. If you prefer a telephone appointment, we will need a good phone number to reach you and your preferred time of day to be called.

To schedule an appointment of if you have questions, please call:

214-820-6200 or 214-820-2078



Wadley 254 Pre Admit
PATIENT PROFILE

PLEASE PRINT ALL INFORMATION

PATIENT INFORMATION

Last Name:________________________ First: ________________________ Middle: ________________________

Address: _____________________________________Apt. No. _________City:___________________________

State: _______Zip: _____________ Drivers License #:__________________

Home Phone: ( ) _________________ Cell Phone: ( )____________________ DOB _______/_______/_______
(Please indicate preferred number with an asterisk *)

Soc Sec # _____- _____- _____ Gender: M___ F___ Ethnicity: White___ Black___ Hispanic___ Other _______

Marital Status: M___ D___ W___ S___ Separated ___ Other ___________ Spouse's Name: __________________

Religious Preference: _____________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ____Relationship: ___________

Home Phone: ( ) ____________________Work Phone: ( ) ______________________

Cell Phone: ( ) ____________

EMPLOYMENT INFORMATION

Name of Employer: ________________________________ Occupation: ___________________________________

Address: _______________________________City: ____________________ State: _______ Zip: ______________

Phone: ( ) _________________
- **If you are retired, please provide retirement date: Month____Day____Year____**
- **If you spouse is retired, please provide retirement date: Month_____Day_____Year_____**

ACCIDENT INFORMATION

Was your injury an accident? Yes __ No __ If yes, please answer the following questions:

Date: ___ /___ /____ Time: _____ am/pm Location: ______________ Description: _________________________

Work related: Yes __ No __ If yes, please answer the following questions:

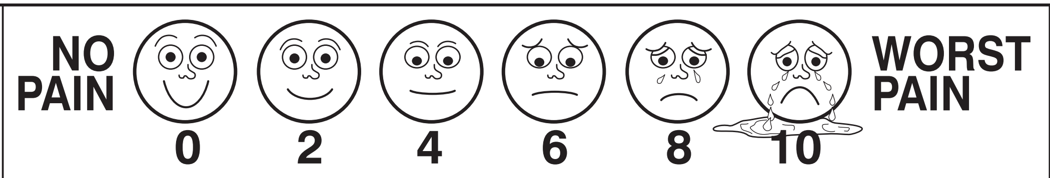
Supervisor: ___________________ Phone ( ) _________ Adjuster Info: _________________________________

ADMISSION PROCESS

1. Initiates the Admission Data Base, the Transdisciplinary Discharge and the Interdisciplinary Teaching Record Planning information within 24 hours of admission or as soon as practical on adult medical surgical units.
2. Ask the patient/significant other if available, to assist with the completion of the Admission Data Base, Transdisciplinary Discharge Planning, and Interdisciplinary Teaching Record information.
3. Initiates the physical assessment within the time frame per structure standard using the Physical Assessment Protocol. Exceptions are noted on the Focus Notes.
4. Completes the skin assessment figure on the Admission Database. If an ostomy is present, an Enterostomal Therapy screening is entered on BCON. If wound or skin breakdown present, initiates the Standing Delegated Medical Orders for Skin and Wound Care.
5. Assures patient identification bracelet is on.
6. Assess pain.
   Instructs on the use of the Pain Scale.
   Circles the number corresponding to the intensity on the scale.
   Identifies the patient unable to participate in the pain assessment.
7. Reviews the Nutrition/Metabolic screen on admission. Enters a Nutrition Evaluation on BCON if any of the criteria are marked yes or if patient has a Stage II or greater ulcer .
8. Reviews the Functional (Mobility/Activity) screen on admission.
   INSTRUCTIONS:
   If the patient checks "Yes" to an item, assess the patient and if needed request a physician order for Physical Therapy evaluation and treatment:
   Getting in and out of bed
   Coming to standing from chair/toilet
   Walking w/wo cane/crutches/walker
   Falls
   Dizziness/loss of balance
   If the patient checks "Yes", assess the patient and if needed request a physician order for Occupational Therapy evaluation and treatment:
   Completing personal hygiene/grooming
   If the patient checks "Yes", assess the patient and if needed request a physician order for Speech Therapy evaluation and treatment:
   Swallowing and communication
9. Notes allergies on: Admission Data Base, arm band, BCON and front of the chart.
10. Gives patient the Advanced Directive information. If patient cannot receive the information, gives to family/significant other and assesses periodically when patient can be given the information. Enters all on BCON.
11. Enter patient's height and weight on BCON
12. Reviews Immunization screen on admission. Initiates Standing Delegated Medical Order if appropriate.
13. Orients the patient or responsible party to:

Call light	Bed operation	Telephone
Visiting hours	Meal times	Smoking policy
Use of side rails	Valuables policy	Television
Room lights		

14. Initiates Focus List with appropriate goals.
15. Initiates CarePath if applicable
16. Reviews the Transdisciplinary Discharge Planning screening criteria and makes appropriate referrals. Places under the Discharge Planning tab in the chart.
17. Assess for Medical Alert condition on admission and enter on BCON if present.
18. Gives patient/family the Health Promotion Brochure and completes assessment of the Interdisciplinary Patient Teaching Record.
19. Reviews Suicide Ideation screen. Notifies attending physician to evaluate the patient for a Psychiatric Consult if the patient marks they are having thoughts of suicide or harming themselves.



No Pain | Mild Pain | Pain | Very | Worst Possible

BAYLOR UNIVERSITY MEDICAL CENTER
An Affiliate of Baylor Health Care System

FORM NO. 028735 (3/02)
MRC-11/91

ADMISSION DATA BASE INFORMATION

DIRECTIONS: PLEASE COMPLETE THE FOLLOWING. DO NOT COMPLETE AREAS OUTLINED WITH DASHED LINES.

I. HEALTH PERCEPTION AND HEALTH MANAGEMENT

What **HEALTH PROBLEM** brought you to the hospital? ______________________________

____

Do you have a **HISTORY** of:

- Seizures ❑ No ❑ Yes
- Lung Disease ❑ No ❑ Yes
- Heart Attack ❑ No ❑ Yes
- Heart Disease ❑ No ❑ Yes
- Chest Pain ❑ No ❑ Yes
- Transplant ________ ❑ No ❑ Yes
- Gum Infection ❑ No ❑ Yes
- Dental Cavities ❑ No ❑ Yes
- Cancer ❑ No ❑ Yes
- Liver Disease/Hepatitis/Cirrhosis ❑ No ❑ Yes
- Kidney / Bladder Disease ❑ No ❑ Yes
- Stomach Disease ❑ No ❑ Yes
- Bowel Disease ❑ No ❑ Yes
- Sleep Apnea ❑ No ❑ Yes
- Use of BiPAP/CPAP ❑ No ❑ Yes
- Stroke ❑ No ❑ Yes
- Blood or Bleeding Disorders ❑ No ❑ Yes
- Increased Cholesterol ❑ No ❑ Yes
- Diabetes ❑ No ❑ Yes
- High Blood Pressure ❑ No ❑ Yes
- Are you now or could you be pregnant? ❑ No ❑ Yes
- Date of Last Menstrual Period ____________
- Hemodialysis Patient ❑ No ❑ Yes
  - Access Site ______________________
  - Dialysis Schedule M W F T TH S
- Peritoneal Dialysis ❑ No ❑ Yes
  - Dialysis Solution ______________________
  - Dwell Time ____________________ Hrs.
  - Number of Exchanges per day ________
  - Methicillin-resistant Staphylococcus Aureus ❑ No ❑ Yes
  - Vancomycin-resistant Enterococci ❑ No ❑ Yes
- ❑ Other (Specify): ____________________

List all **SURGERIES** you have had, including dates:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Previous Adverse Reaction to Anesthesia ❑ No ❑ Yes Describe ____________________

Do you have any **IMPLANTS** / **PROSTHETICS?** ❑ No ❑ Yes If yes, please check those applicable:

❑ Lens Implants ❑ Pacemaker / Implantable Cardio Defibrillator ❑ Joint Replacement ❑ Pins / Rods ❑ Prosthetic Valves

❑ Implantable Pump / Devices __________________ Medication ❑ Stent Location ______________________________

❑ Tracheostomy Size ___________________ ❑ Other: ______________________________

Have you smoked any type of tobacco (cigarettes, cigars, pipes) in the past twelve months?

❑ No ❑ Yes Within the last 30 days? ❑ No ❑ Yes

Have you used any type of smokeless product (chewing tobacco, snuff, chewing unlit cigar, dip) in the past twelve months?

❑ No ❑ Yes Within the last 30 days? ❑ No ❑ Yes

If you use tobacco products, have you been encouraged to quit and given written information about quitting?

❑ No ❑ Yes If yes, when? ______________________________

If you use tobacco products would you be interested in an alternative nicotine product while in the hospital? ❑ No ❑ Yes

Patient received smoking cessation / prevention information at time of admission: ❑ No ☑ Yes

Do you drink **LIQUOR** / **BEER** / **WINE?** ❑ No ❑ Yes If yes, how much? ______________________ How Often? _______________

Are you or any family member concerned about your alcohol use? ❑ No ❑ Yes

Are you interested in speaking with someone about available treatment options or resources? ❑ No ❑ Yes

IMMUNIZATIONS: Have you had the following immunizations ?

- Tetanus vaccine in the last 10 years ❑ No ❑ Yes
- Pneumococcal vaccine ❑ No ❑ Yes
- Hepatitis B vaccine ❑ No ❑ Yes
- Flu shot in the past year ❑ No ❑ Yes
- TB test within the past year ❑ No ❑ Yes
  - If Yes, results were ❑ Positive ❑ Negative
- Have you ever received the Bacillus Calmette Guerin vaccine (BCG)? ❑ No ❑ Yes

MED REC NO. ______________________________

PATIENT ______________________________

PHYSICIAN ______________________________

BILLING NO. ______________________________

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

028735 (Rev. 04/09) (47415)

Medication List

List all prescriptions, non-prescription, supplement and herbal supplements or routine medications taking

NO	NAME OF DRUG	DOSE AMOUNT	HOW MANY TAKEN	SCHEDULE	LAST DOSE	WHY TAKING WHY PRESCRIBED
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						

Not a Permanent Part of the Medical Record.

FORM NO. 028735 (3/02)
MRC-11/91

VII. PAIN ASSESSMENT

Are you having **PAIN** / **DISCOMFORT** ***NOW?*** ❑ No ❑ Yes

If yes, please describe: ______________________________

Have you had recent **PAIN** / **DISCOMFORT?** ❑ No ❑ Yes

If yes, please describe: ______________________________

____

If you are having pain or have recently experienced pain, please answer the following questions:

What was your worst pain in the last 24 hours? ________________

Where is your pain located? ________________

When did the pain start? ________________

Is the pain constant or intermittent? ________________

Any other associated symptoms? ________________

What makes the pain better? ________________

What makes the pain worse? ________________

Have you experienced this pain before? ❑ No ❑ Yes

What treatments have you tried that makes the pain better? ________

____

What treatments have you tried that do not help your pain? ________

____

Is your pain affecting your daily activities? ________________

Is your current level of pain acceptable? ❑ No ❑ Yes

Patient unable to participate in pain assessment? ❑ No ❑ Yes

Current PAIN (Circle one)	**0 1 2 3 4 5 6 7 8 9 10**
Pain in the last 24 hours (Circle one)	**0 1 2 3 4 5 6 7 8 9 10**

VIII. ROLE / RELATIONSHIP

Do you feel safe in your relationships at home? ❑ No ❑ Yes

Would you like information regarding family violence? ❑ No ❑ Yes

IX. COPING / STRESS

Any recent **CHANGES IN YOUR LIFE** related to your family, job, home, etc.? ❑ No ❑ Yes

If yes, please describe: ______________________________

____

How do you cope with stress? ______________________________

____

Are you feeling hopeless or worthless? ❑ No ❑ Yes

If yes, please answer the following question.

Are you having thoughts of suicide or harming yourself?

❑ No ❑ Yes

X. HEALTH PERCEPTION / HEALTH MANAGEMENT PATTERN

Please complete the following information to help us plan for your discharge.

Are you responsible for the care of anyone else? ❑ No ❑ Yes

If yes, whom? ______________________________

Who will be helping with your care when you leave?

Name: ______________________________

Relationship: ________________ Phone: ________________

Did any agencies or people help you with your care before you came to the hospital? (Home Health, neighbor, family, other)? ❑ No ❑ Yes

If yes, list Name/Agency: ______________________________

Do you use any type of medical equipment? ❑ No ❑ Yes

If yes, check all that apply

❑ BiPAP	❑ CPAP	❑ Walker
❑ Cane	❑ Crutches	❑ Wheelchair
❑ Commode	❑ Prosthesis	❑ Other ________

Do you anticipate returning home after this hospitalization? ❑ No ❑ Yes

If No, where do you anticipate going? ______________________________

XI. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

If returning home, do you need help with any of the following activities?

Transportation – ***driving or arranging for public transport***	❑ No	❑ Yes
Meal preparation – ***plan and prepare a meal, use stove safely***	❑ No	❑ Yes
Shopping and Errands – ***shop alone for groceries***	❑ No	❑ Yes
Household Chores – ***wash dishes, sweep, mop***	❑ No	❑ Yes
Money Management – ***pay bills, keep checkbook, manage affairs***	❑ No	❑ Yes
Medication Management – ***know what each medication is for, when/how to take it***	❑ No	❑ Yes
Do you anticipate any needs at discharge?	❑ No	❑ Yes

XII. EMERGENCY CONTACTS

NAME/RELATIONSHIP	PHONE NUMBER

XIII. INFORMATION GIVEN BY

____
Informant

Date: ________ Time: ________ Relationship to Patient: ________________

MED REC NO. ______________________________

PATIENT ______________________________

PHYSICIAN ______________________________

BILLING NO. ______________________________

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

028735 (Rev. 04/09)

ADMISSION DATA BASE INFORMATION
ADULT MEDICAL SURGICAL PAGE 3 OF 4 **D-202**

FORM NO. 028735 (3/02)
MRC-11/91

List all allergies / intolerances and reactions (food, drug, environmental, latex, iodine, shellfish, contrast medium.)

ALLERGY / INTOLERANCE	DESCRIBE REACTION

II. NUTRITION / METABOLIC

HEIGHT: ________________ **CURRENT WEIGHT:** ____________

(check all that apply)

Lost 10 pounds or more in the past month without trying	❑ No	❑ Yes
Poor appetite over the last month	❑ No	❑ Yes
Follow a lactose (milk) free or gluten (wheat) free diet	❑ No	❑ Yes
Patient in ICU, Oncology	❑ No	❑ Yes
Difficulty chewing or swallowing	❑ No	❑ Yes
Need education on current diet	❑ No	❑ Yes
Religious or cultural dietary requirements	❑ No	❑ Yes
On tube feeding/IV nutrition	❑ No	❑ Yes
Non-healing wound or pressure ulcer	❑ No	❑ Yes

III. ELIMINATION

Do you have any problems with **URINATION?** ❑ No ❑ Yes

If yes, specify: ____

____

____

Ostomy ________________________________ ❑ No ❑ Yes

Type: ____________________________

Do you have any problems with bowel movements? ❑ No ❑ Yes

❑ Diarrhea ❑ Other: ________________ ❑ None of these
❑ Constipation

Specify: ____

____

Ostomy ________________________________ ❑ No ❑ Yes

Type: ____________________________

When was your **LAST BOWEL MOVEMENT?** ______________

____

How often do you have **BOWEL MOVEMENTS?** ____________

____

____

IV. MOBILITY / ACTIVITY

Over the LAST TWO WEEKS, have you developed any or greater difficulty with the following activities?

Getting in and out of bed	❑ No	❑ Yes
Coming to standing from a chair/toilet	❑ No	❑ Yes
Walking w/wo cane/crutches/walker	❑ No	❑ Yes
Falls	❑ No	❑ Yes
Dizziness/loss of balance	❑ No	❑ Yes
Completing personal hygiene/grooming needs	❑ No	❑ Yes
Swallowing or communication	❑ No	❑ Yes

V. COGNITIVE / PERCEPTUAL / EDUCATION

Do you have to **Wear**:

GLASSES / CONTACT LENSES? ❑ No ❑ Yes
HEARING AID? ❑ No ❑ Yes
If Yes, ❑ Left ear ❑ Right ear ❑ Both

What level of **EDUCATION** have you completed? ______________

Do you **READ MAGAZINES, BOOKS, AND / OR NEWSPAPERS?** ❑ No ❑ Yes

How do you prefer to learn? ❑ Reading ❑ Hearing ❑ Watching ❑ Doing
(Mark all that apply)

Primary **LANGUAGE** spoken: ____________________________

Interpreter Required? ❑ No ❑ Yes

Do you have changes in thought processes/behavior? ❑ No ❑ Yes

❑ Mental Status ❑ Memory (recent/remote) ❑ Learning Ability
❑ Decision making/judgement

VI. VALUE / BELIEF

Do you have a **RELIGIOUS, SPIRITUAL AND/OR CULTURAL TRADITION** we need to consider? ❑ No ❑ Yes

If yes, specify:

____

____

____

____

MED REC NO. ____________________

PATIENT ____________________

PHYSICIAN ____________________

BILLING NO. ____________________

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

028735 (Rev. 04/09)

ADMISSION DATA BASE INFORMATION
ADULT MEDICAL SURGICAL **D-202**

FORM NO. 028735 (3/02)
MRC-11/91

XIV. MRSA SCREENING

Do you have any of the following:

Hospitalization within the past year	❑ No	❑ Yes
Transferred from an extended care facility	❑ No	❑ Yes
Currently have open or draining skin wounds	❑ No	❑ Yes
Currently on dialysis	❑ No	❑ Yes
Currently admitted to Intensive Care Unit	❑ No	❑ Yes

XV. SCREENINGS (To be completed and entered into BCON by the NURSE)

Advance Directives	❑ No	❑ Yes
Allergies/Allergy Identification Bracelet Applied	❑ No	❑ Yes
Care Coordination	❑ No	❑ Yes
Care Path Initiated	❑ No	❑ Yes
Enterostomal Therapy (ostomy only)	❑ No	❑ Yes
Immunizations (Initiates Standing Delegated Medical Orders For Immunization)	❑ No	❑ Yes
MRSA Screen (Obtains nasal swab if patient answers yes to any of the screening questions)	❑ No	❑ Yes
Nutrition (complete on admission)	❑ No	❑ Yes
Physical Medicine (complete on admission)	❑ No	❑ Yes
Social Work	❑ No	❑ Yes
Suicide Ideation	❑ No	❑ Yes

XVI. NOTES

XVII. PERSONAL BELONGINGS (To be completed by the Nurse)

Only indicate the belongings the patient has with them with checkmarks

Fill in appropriate boxes	Medications	Cash/Checks	Credit Cards	Wallet	Jewelry	Watch	Contacts	Glasses	Crutches	Cane/Walker	Hearing Aid	Partials/Dentures Upper	Partials/Dentures Lower	Clothing	
ED															
Room															
Family															
BUMC Cashier															
Other															

❑ Belongings collected in the ED

XVIII. SKIN ASSESSMENT (To be completed by the Nurse)

DIAGRAM CODES

Abrasions - **A**
Burns - **B**
Contusions - **C**
Erythema - **E**
IV-Access - **I**
Laceration - **L**
Mottled - **M**
Ostomy - **O**
Petechia - **P**
Rash - **R**
Scar - **S**
Ulcer - **U**

❑ Skin Assessment Within Normal Limits

XIX. INFORMATION OBTAINED BY

Nurse Signature ______ Initials ______

Date: ______ Time: ______

Nurse Signature ______ Initials ______

Date: ______ Time: ______

Legend: **BCON** = Baylor Computer Online Network **BHCS** = Baylor Health Care System **BiPAP** = Bi-Level Positive Airway Pressure **BIR** = Baylor Institute for Rehabilitation **BSH** = Baylor Specialty Hospital **CHF** = Congestive Heart Failure **COPD** = Chronic Obstructive Pulmonary Disease **CPAP** = Continuous Positive Airway Pressure **CVA** = Cerebrovascular Accident **ED** = Emergency Department **F** = Friday **HIV** = Human Immunodeficiency Virus **ICU** = Intensive Care Unit **IV** = Intravenous **L** = Left **M** = Monday **MRSA** = Methicillin Resistant Staphylococcus Aureus **MS** = Multiple Sclerosis **OBS** = Organic Brain Syndrome **R** = Right **S** = Saturday **Th** = Thursday **TB** = Tuberculosis **T** = Tuesday **W /Wo** = with/without **W** = Wednesday

MED REC NO. ______
PATIENT ______
PHYSICIAN ______
BILLING NO. ______

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

028735 (Rev. 04/09)

ADMISSION DATA BASE INFORMATION
ADULT MEDICAL SURGICAL PAGE 4 OF 4

PHYSICAL ASSESSMENT

Pattern	Assessment
II Nutritional / Metabolic III Elimination	**INTEGUMENTARY** Skin color normal for race/ethnic background. Warm, dry & intact.
	GASTROINTESTINAL Bowel sounds active in all 4 quadrants. Abdomen soft. No distention. No pain with light palpation (nontender). No nausea or vomiting. No stomas or wounds.
	GENITOURINARY Bladder evacuated without difficulty. No incontinence. No stomas. If Foley present, urine clear, yellow, and draining.
	INTRAVENOUS (peripheral or central, if applicable) IV fluid infusing well without difficulty or intermittent device (saline lock) flushes well. No redness or swelling noted at IV site. Site and tubing (if applicable) meet date requirements for change. Dressing on IV site is clean, dry, and intact.
	INCISION/WOUND (if applicable) Dressing, if present, is clean, dry, and intact. No evidence of redness, swelling, increased temperature, or pain in surrounding tissue. No purulent drainage. Sutures, staples, or steristrips are dry and intact with wound edges approximated. Pin site (if applicable) is clean, dry, and without evidence of purulent drainage. Tubes/drains (if applicable) are patent and activated.
IV Mobility/Activity	**CARDIOVASCULAR** Regular apical pulse 60 to 100. Peripheral pulses present & equal. Assessment as appropriate for patient condition. No edema. No chest pain. Blood pressure within normal limits for patient.
	RESPIRATORY Respirations 10 to 20 per minute at rest. Respirations regular. Lungs clear all lobes. Not using accessory muscles in respiratory effort. Nailbeds pink. No stomas.
	MUSCULOSKELETAL Moves all extremities. Gait & ambulation appropriate.
V Cognitive/Perceptual II Nutritional/Metabolic	**EYE, EAR, NOSE & THROAT** Able to read instructions. Able to hear instructions or conversation. Able to chew and swallow.
V Cognitive/Perceptual	**NEUROLOGICAL** Alert & oriented to person, place & time. Behavior appropriate to situation. Speech clear & understandable.

MEDICAL ALERT CONDITIONS

IF ANY OF THESE CONDITIONS ARE PRESENT ENTER ON BCON

- ALTERED MENTAL STATUS
- AMPUTEE
- ANTICOAGULANTS
- ASTHMA
- APHASIA
- BLINDNESS
- DEAF
- DIABETES
- FALL PRECAUTIONS
- HEARING IMPAIRMENT
- HYPERTENSION
- IMMUNOSUPPRESSED
- NO PERIPHERAL STICK OR BP MEASUREMENTS R OR L ARM
- NO ENGLISH
- MINIMAL ENGLISH
- PACEMAKER
- PROSTHESES
- SEIZURES
- SIDUS INVERSUS (TRANSPOSITION OF ORGANS)

ADVANCE DIRECTIVE TRACKING FORM

Dear Patient: Please complete the following questions. This form will become part of your medical record. We are required to obtain this information by our accreditation organization and by Federal Law.

1. Do you have any of the following Advance Directives (check all that apply)?
   ______ Medical Power of Attorney ______ Living Will
   ______ Out of Hospital Do Not Resuscitate ______ Mental Health Directive

2. If you have any of these documents and do not have a copy with you, where is it located? ____________________________________ ____________________.
   Can someone bring a copy to the hospital? ____ yes ____ no

3. If you do not have an Advance Directive and wish to complete one, we will provide you with the proper forms and other information needed to complete the directive.

4. If you have an Advance Directive but a copy is not available at this time, what does your Advance Directive say about your treatment wishes if you become terminally or irreversibly ill and are unable to make your wishes known?

   ____

   ____

   ____

5. If we are unable to communicate with you as a result of your illness, who should we speak with on your behalf?

   ____
   Name Relationship Phone Number

6. ___ I do not wish to make an Advance Directive at this time.

I am aware that if I become unable to make decisions for myself and I have not completed an Advance Directive, state law will require that my physicians turn to the following persons in the order listed for medical decision-making: my spouse, my reasonably available adult children, my parents, or my nearest living relative. If none of those persons are available or willing to act on my behalf, I am aware that state law allows my doctors to turn to the hospital's medical ethics committee or to a court of law for medical decision-making.

_________________________________ Patient Signature ____________________ Date

This information will be available for your doctor. However, if you have questions or wish to discuss this further with him/her, please let us know.

For hospital staff use only: Please date the following when completed (if applicable):

Patient unable to discuss (re-assess daily).
Information given to family/surrogate.
Advance Directive placed on medical record.
Personal choices brochure given
___ to patient ___ to family

___ Advance Directive sticker placed in MD
___ notes.
___ Advance Directive information entered on
___ BCON.
___ Patient desired more information —
___ referral to Pastoral Care made.

_________________________________ RN Signature ____________________ Date
_________________________________ MD Signature ____________________ Date

MED REC NO. ______________________________

PATIENT ______________________________

PHYSICIAN ______________________________

BILLING NO. ______________________________

BAYLOR UNIVERSITY MEDICAL CENTER
Dallas, Texas

43385 (Rev. 3/04)

ADVANCE DIRECTIVE TRACKING FORM

H-277

TRANSDISCIPLINARY DISCHARGE PLANNING

SCREENING CRITERIA

PLEASE SEND REFERRAL TO SOCIAL SERVICES IF DISCHARGE PLANNING ASSISTANCE NEEDED.

Use as guide to determine the need for discharge planning, with consideration of physical, emotional, environmental and mental status needs at the time of discharge.

1. Age - 70 and over with inadequate home environment.
2. No known family, friends or method of follow-up contact.
3. Patients hospitalized due to non-compliance with medical regime.
4. Suicide risk gesture or attempt.
5. Admissions from or to Extended Care facility.
6. Admission for Rehabilitation Services outside BHCS.
7. Patients whose illness will necessitate a change in lifestyle, etc.
8. Admission diagnosis needing immediate discharge planning:
   a. Aneurysm
   b. Neurological disorders (spinal cord injuries, sub-arachnoid hemorrhage, sub-dural hematoma, brain tumor, coma).
   c. CVA
   d. Dementia (OBS or other mental debility)
   e. Malnutrition/Dehydration
   f. Pressure ulcers
   9. Hip fracture
   h. Carcinoma
   i. Chronic illness (COPD, CHF, etc.)
   j. Multiple trauma
9. Hospice or Palliative Care referral
10. Transportation needs
11. Take home medication
12. Substance abuse
13. Suspected abuse or neglect
   a. Untreated old injuries, multiple injuries in varying stages of healing.
   b. Extent or type of injury is inconsistent with explanation patient gives, or there are conflicting histories of injury.
   c. Injuries are on areas of the body normally covered by clothing.
   d. History of being "accident prone", or having many previous injuries.
   e. Describes the accident in a hesitant, embarrassed, or evasive manner.
   f. Verbal or nonverbal indications of abuse, neglect, or domestic violence.
14. Indigent (Resources Unknown)
15. "John Doe"
16. Educational needs for children and adolescents
17. All transplants
18. Complex discharge planning needs
19. Numerous recent admissions
20. Ventilator dependent
21. Tracheotomy patient with need for long term care
22. Any criterion selected related to instrumental activities of daily living

CARE COORDINATOR REFERRAL:

IF NURSING ASSESSMENT DEMONSTRATED ANY OF THE FOLLOWING:

1. Age - 70 and over with inadequate home environment.
2. Admission diagnosis needing immediate discharge planning:
   a. CVA, Myocardial Infarction
   b. Head/Multiple Trauma, Spinal Cord
   c. Injuries, Dementia
   d. Carcinoma
   e. Septicemia
   f. Severe Activity limiting articular restriction, fractures, MS, amputation
   g. Malnutrition/Dehydration
   h. Pressure ulcers
   i. Diabetes (newly diagnosed or with complications)
3. Complex Discharge Planning Needs
4. Chronic illness (COPD, CHF, HIV, Asthma (adult, child)
5. Numerous recent admissions
6. Patients hospitalized due to non-compliance with medical regime
7. Ventilator dependent patient
8. Tracheotomy patient with need for long term care
9. Home Health/Durable Medical Equipment
10. Acute care rehab needs within Baylor (BIR, BSH referrals)
11. Long Term IV Antibiotics
12. Patients needing take home meds.
13. Care path patients
14. All transplants

During your stay at Baylor, we would like to provide you with the following health promotion, risk management and wellness information to help you

maintain a healthy lifestyle.

HEART AND VASCULAR INFORMATION

Baylor Health Care System offers full-service heart and vascular services at a variety of Baylor locations.

Cardiovascular Disease

Risk Factors for Heart Attack and Stroke (also called Brain Attack)

Cardiovascular disease is the number one cause of all deaths in the United States, both in men and women. Becoming familiar with your risk factors, as outlined by the American Heart Association, can decrease your chance of having a heart attack or stroke.

Major Uncontrollable Risk Factors:
Although you cannot alter these risks, awareness of having them makes it even more important to manage your "controllable" risk factors.

- Heredity: Know your family history. You are at greater risk if your mother or sister had a heart attack before age 65, and father/brother before age 55. Also, African Americans, Mexican Americans, native Hawaiians and some Asian Americans have a higher risk of heart disease.
- Increasing Age: Men & women 65 years or older.
- Gender: Men are at greater risk, but cardiovascular disease is the leading cause of death for both men and women.

Risk Factors you can Modify:

- Tobacco use in any form, including exposure to second-hand smoke, can increase risk
- High Blood Cholesterol
- High Blood Pressure
- Physical Inactivity
- Obesity and Overweight
- Diabetes

If you are concerned about your risk factors, please discuss risk management with your health care provider. Call **1-800-4BAYLOR** for cardiovascular information. You can also call 1-800-AHA-USA1 for information on heart disease, or 1-888-4-STROKE for information on Stroke. On the Internet, go to (on back) **www.americanheart.org*** or **www.LeapforLife.com.**

GENERAL WELLNESS INFORMATION

Substance Abuse

Substance abuse is alcohol or drugs (legal or illegal) taken in increasing amounts over a longer period than intended. Substance abuse does not necessarily mean you are addicted. If you think you might be addicted or abusing drugs or alcohol, please inform your nurse. We have licensed counselors to assist you. Call the Baylor Center for Psychiatry & Addictive Diseases at (214) 820-7676 or talk to your healthcare provider.

You may want to use this easy assessment … it's the CAGE Assessment Tool

C = Cutdown: Ever feel the need to cut down?
A = Annoyed: Ever feel annoyed by criticism from others about drinking/drugs?
G = Guilty: Ever felt guilty about drinking/drugs?
E = Eye-opener: Ever drank/used drugs to get going in the morning?

Family Violence

Many people associate abuse with physical violence only. Abuse also can be verbal or emotional. Abuse in any form is an action of control. Your physician, nurse or social worker can provide you with more information, a safety plan and available community resources. If you have needs, please ask for the telephone number of the Social Work Department at your Baylor facility or call **1-800-4BAYLOR** and ask for the Social Work Department.

Immunization

Immunizations can protect against many diseases in adults as well as children. Diseases such as hepatitis, influenza, pneumonia, tetanus, mumps, measles, and rubella can be prevented or the effects lessened with vaccination of the adult patient. Children have specialized immunization needs for prevention of childhood diseases. Check with your family doctor if you think you or your child need immunizations.

Contact Centers for Disease Control and Prevention at 1-800-232-2522 (English) 1-800-232-0233 (Spanish) CDC website at **www.cdc.gov.nip***

Mental Health
There is always an emotional/psychological component to every illness or hospitalization. If you or your family member needs assistance, do not hesitate to notify your nurse, primary care provider or social worker. You may also call the Baylor Center for Psychiatry & Addictive Diseases at (214) 820-7676.

Tobacco Cessation
Giving up the use of ALL tobacco products is one of the most important things you can do to improve your health and the health of those around you. Tobacco products include cigars, cigarettes, chew, dip and snuff. Nicotine, which is addictive, is in all forms of tobacco. Nicotine is what can make quitting so difficult. The good news is that help is available. If you are interested in learning more, please speak with your healthcare provider.

CANCER INFORMATION

Baylor Cancer Centers treat all forms of cancer. For information, referrals or services, please call 1-800-4BAYLOR or talk with your healthcare provider. You may access the American Cancer Society on the internet at **www.cancer.org*.**

Breast Cancer
Baylor follows the American Cancer Society (ACS) guidelines** for breast cancer screening of women without symptoms:

- A mammogram every year for all women age 40 or older (screening may begin earlier if clinically indicated).
- Clinical breast exam by a health care professional every 3 years for women age 20 to 39, and annually for women age 40 and older.
- Breast self-exam monthly for all women age 20 and older.

** Guidelines for screening without symptoms of breast disease and with normal risk for cancer. The presence of a strong family history of breast cancer or other factors may alter these recommendations. Please check with your healthcare provider if you need direction to the most convenient Baylor Cancer Center.

Colorectal Cancer
Baylor follows the American Cancer Society guidelines for early detection of colorectal cancer. Beginning at age 50, men and woman should have a fecal occult blood test and flexible sigmoidoscopy. Repeat the fecal occult blood test annually and the sigmoidoscopy every 5 years, or have a colonoscopy at 10-year intervals, or have a double-contrast barium enema every 5 to 10 years. You may ask your healthcare provider for further information.

Pap Test
The Pap test can detect early, "pre-cancerous" cell changes in the cervix. Baylor follows the American Cancer Society recommendations that all women who have reached the age of 18 or have been sexually active have a Pap test and pelvic exam every year. Please discuss any questions with your healthcare provider.

Prostate Cancer
Baylor follows the American Cancer Society guidelines for early detection of prostate cancer. Men should have a prostate-specific antigen (PSA) blood test and digital rectal exam (DRE) every year, starting at age 50. African-American men and men who have two or more close relatives (father or brothers) with prostate cancer should begin screenings at age 45.

Skin Cancer
Baylor recommends avoiding prolonged exposure to the sun, especially during the midday. These actions can help prevent most skin cancers. Wear protective clothing—hats with brims, long-sleeved shirts—and use sunscreen on all exposed parts of the skin. If you have children, protect them from the sun and don’t allow them to become sunburned. Examine your skin regularly for irregular moles, and have a skin exam during your regular health checkups.

BAYLOR HEALTH CARE SYSTEM

Baylor hopes you have found these wellness tips helpful. As a leader in cancer, heart, and vascular care, Baylor provides a variety of services from prevention to clinical research. If you need more information regarding good health tips or illness prevention, please call **1-800-4BAYLOR** or visit **www.bswhealth.com.**

*Baylor does not own or produce these websites. However, as a public service to you, Baylor is providing you with this resource information. Baylor does not sponsor or endorse the websites or the contents of the websites. If you have any questions, please contact your healthcare provider.

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