Pre-admission date/initials: __________________ _____ 30 day readmission

Date: __ /___/____ Time: ___________ Patient prefers to be called: ________________________________________________

Arrived From: □ ER □ Home □ Other: __________________________________________________________________

Source of Information if other than patient: □ family □ SO □ friend □ interpreter □ other documents: transferred records or old AHC records □ Hx incomplete due to: (explain)

Reason for Admission: (In your words, why you are here?)________________________________________________________

Emergency Contact: (Not listed on the face sheet):
Name ______________________________________________ phone___-___-______ cell___-___-______ pager___-___-______
Who helps you in time of need? __________________________________________________________ phone___-___-______

Communication: Primary Language: □ English □ Spanish □ Russian □ Hmong □ other:__________________________
Able to read English □ Yes □ No □ Interpreter Notified (T) □ Interpreter services refused by pt./family

Religion: Are there religious/spiritual/cultural factors that would help us give you more personalized care? (Not religious affiliation) Describe: _______________________________________________________________________________________

Past Hospitalizations, Illnesses or Surgeries: (yr. if known)
Have you or your relatives had any problem with anesthesia/sedation (high fever, difficulty awakening)? □ No □ Yes
If yes explain: __________________________________________

Immunizations: Up to date? □ Yes □ No - Explain ________________________________________________________________________ □ Unknown

Allergy: Refer to "Allergy Report" form in the medical record. Home Medication(s): Record on region specific form.

Health Care Providers: (Not listed on the face sheet) □ No primary health care provider: (T)
Other provider: NP, Chiropractor, physician specialist (i.e. Card., OB, Endo. etc.) Indicate Name/Speciality and last seen if known.
List: ___________________________________________________________________________ Last seen:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Violence/Abuse: Have you ever been threatened, controlled or made to feel afraid of someone? □ Yes □ No □ Declined
Are you currently in a relationship where you have been hit, hurt threatened or otherwise frightened? □ Yes □ No □ Declined
If YES: what needs might you have during this visit? (i.e. Safety, privacy, risk of flashback, difficulty with Examinations / Procedures / Sedation) ______________________________________________________________________________________
Would you like to talk about it? □ Yes (T) □ No □ Declined
Are you a member of a gang or do you have friends who are gang members? □ Yes □ No □ Declined
## Recommended Childhood and Adolescent Immunization Schedule
### United States, 2003

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2002, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine’s other components are not contraindicated. Providers should consult the manufacturers’ package inserts for detailed recommendations.

Approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip), the American Academy of Pediatrics (www.aap.org), and the American Academy of Family Physicians (www.aafp.org).

Table found at www.cdc.gov/rip/recs/child-schedule.pdf

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<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mos</th>
<th>4 mos</th>
<th>6 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>24 mos</th>
<th>4-6 yrs</th>
<th>11-12 yrs</th>
<th>13-18 yrs</th>
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<tbody>
<tr>
<td>Hepatitis B¹</td>
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<td>Diphtheria, Tetanus Pertussis²</td>
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<tr>
<td>Haemophilus Influenzae Type b³</td>
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<td>Inactivated Polio</td>
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<tr>
<td>Measles, Mumps, Rubella⁴</td>
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<td>Varicella⁵</td>
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<td>Pneumococcal⁶</td>
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</tbody>
</table>
Complementary Therapy: □ Aromatherapy □ Acupuncture/pressure
□ Herbal medicine □ Therapeutic touch □ Biofeedback □ Reflexology
□ Other: ___________________________

Family History: □ Unknown □ Arthritis □ Cancer □ Depression
□ Diabetes □ Emotional Problems □ Heart Disease
□ High Blood Pressure □ Lung Disease □ Malignant Hyperthermia
□ Seizures □ Stroke □ Other________

Tobacco: Do you use tobacco? □ Yes □ No
Have you ever smoked? □ Yes □ No
Type: □ cigarettes □ cigars □ chewing pipe □ other: ___________________________
Pack year history. ____________ (PPD X number of years smoked = pack year history).

When did you quit? (yr) __________ Does anyone in the home smoke? □ Yes □ No
Are you ready to quit? □ Yes □ No; Would you like smoking cessation materials? □ Yes □ No
(T) (doc. on Education Record)

ETOH: Do you drink alcohol? □ No, if no stop here □ Yes, # days / wk ____________
□ 1 or more days/wk (T)

If NONE: stop here do not ask the CAGE questions. Cage questions are only for inpatients.

On a typical day when you drink, how many drinks do you have? __________ Amount # / day
□ 1 or more/day (T)

Recreational Drugs: (list) ____________________________________________, last use: ____________

ADL: □ Independent □ Needs assistance
Nutrition: Change in: □ Appetite □ Eating habits □ Wt. Loss □ Wt. Gain □ Other: ____________
(Day any response)
□ Self feed □ Assist □ Cup □ Spoon □ Fork □ Straw □ Bottle □ Breast □ Other: ____________
Eats how many times a day ____________.
Name of formula ___________________________
□ Ounces taken / day _________, Eats every _____ Hours

Special needs: □ What are your child’s words for Stool ____________ Urine ____________

Current Deficits: Age specific deficit present? □ Yes, if yes list ____________ □ No

Home assistance/services: Agency: ____________________________
□ Type of Services: □ RN □ NA □ Therapist (list provider):
□ Transportation: _______ □ WIC □ Healthy Start □ OP Therapy: □ PT □ OT □ ST
□ Other: ____________________________

DC Planning Pt/Family DC goal: (T) □ with family □ home with home care □ Hospice □ OP Therapy □ Rehab
□ Assisted Living □ Other: ____________________________

Assistive Devices / Items | Location of Devices / Personal Items (Security envelope receipt on chart or given to patient) | To On DC
--- | --- | ---
Vision □ Glasses □ Contacts □ Pt. responsible (Bedside or secured location in the area) □ Sent Home □ Loss Prevention □ PT □ Family
Hearing Aid □ Right □ Left □ TDD □ Pt. responsible (Bedside or secured location in the area) □ Sent Home □ Loss Prevention □ PT □ Family
□ Upper □ Lower □ Both □ Bridge □ Pt. responsible (Bedside or secured location in the area) □ Sent Home □ Loss Prevention □ PT □ Family
Dental Partial □ Retainer □ Pt. responsible (Bedside or secured location in the area) □ Sent Home □ Loss Prevention □ PT □ Family
Mobility □ Cane □ Walker □ Crutches □ Prosthesis □ Other: ____________ □ Pt. responsible (Bedside or secured location in the area) □ Sent Home □ Loss Prevention □ PT □ Family
Medical Equip. List: ____________________________ □ Pt. responsible (Bedside or secured location in the area) □ Sent Home □ Loss Prevention □ PT □ Family
Personal Items □ Jewelry □ Watch □ Keys □ Wallet/Purse □ Money □ Pt. responsible (Bedside or secured location in the area) □ Sent Home □ Loss Prevention □ PT □ Family

□ Informed of valuables policy - The hospital will not be responsible for the property of the patient.
## DEVELOPMENT PARAMETERS REFERENCE

### Infant (0-364 days)
- Eyes follow caregiver
- Lifts head (when on tummy)
- Raises chest
- Smiles purposefully
- Turns to sound
- Rolls from tummy to back
- Holds head erect (when sitting)
- Makes squeals
- Babbles
- Coos
- Crawls
- Grasps rattle
- Holds a bottle
- Drinks from cup
- Sits alone for several moments
- Has finger-thumb grasp
- Feeds self finger foods
- Looks after object that has fallen
- Transfers block from one hand to other
- Pulls self to stand
- Stands alone
- Walks along furniture
- Says Mama
- Says Dada
- Plays Peek-a-Boo
- Plays Pat-a-Cake

### Toddler (1-3 yrs)
- Plays with ball
- Waves bye - bye
- Separates from mom - short intervals
- Give/take object from offered hand
- Hugs
- Goes up/down stairs
- Alone With help
- Makes a line with crayon
- Does circular scribbling
- Inserts / dumps pellet into bottle
- Follows simple commands
- Tries to unbutton clothing
- Indicates wants by pointing/talking

### Preschooler (3-5 yrs)
- Recognizes body parts
- Jumps and climbs well
- Dress self with help
- Dress self alone
- Buttons clothing
- Ties Shoes
- Washes face
- Brushes teeth
- Hops on one foot
- Walks backward
- Walks in straight line
- Gives full name
- Draws beyond scribble (stick people)
- Uses straw
- Walks stairs with alternating footing
- Separates from mother
- Plays well with others
- Attends preschool or kindergarten
- Toilet trained / daytime: urine stool
- Toilet trained / nighttime: urine stool
- Talking in sentences
- Knows: colors shapes
- Knows age
- Recognizes numbers
- Counts
- Knows difference between alike and different
- Bounces/catches bounced ball
- Goes to bed when told
- Begins to read simple stories

### School age (6 - 12 yrs)
- Follows instructions / rules
- Plays cooperatively in competitive games
- Knows left from right
- Stays overnight at friends' house or left alone at home
- Afraid of dark
- Bath: self with help
- Shower: self with help
- Recognizes letters
- Recognizes numbers
- Add
- Subtract
- Multiply
- Divide
- Reads
- Prints
- Writes
- Can tell time
- Digital Standard
- Rides a bike
- Plays with peer group

### Adolescent (13 yrs - 18 yrs)
- Concern over physical appearance
- Socializes with peer group of same and/or different sex

BIRTH HX

- Prematurity: [ ] Yes [ ] No
- Gestational Age: [ ]
- Birth Trauma: [ ] Yes [ ] No
- Maternal Substance Abuse: [ ] ETOH [ ] Other Drugs
- Subsequent Health Problems: [ ]

PAIN

- What is your child's usual response to pain?
  - Changes in facial expression
  - Tantrums
  - Becomes quiet and withdrawn
  - Cries
  - Alters eating/sleeping habits
  - Other:

- What word does child use to express pain?
  - Owie
  - Pain
  - Sore
  - Hurt
  - Boo-Boo
  - Ouch
  - Other:

- Is there anything besides medication that makes your child feel better?
  - Distraction
  - Reassurance
  - Parent's Voice
  - Familiar Object
  - Touch
  - Cold
  - Rocking
  - Heat
  - Hugs
  - Bottle
  - Play
  - Other:

PSYCH/SOCIAL

- No previous Hx.
- Insomnia
- Anxiety
- Impaired coping
- Bipolar
- Depression
- Self harm (T)
- Schizophrenia
- ADD/ADHD
- Panic Disorder
- Other:

NEURO

- No Previous Hx.
- Visual disturbances
- Dizziness
- Fainting
- HA
- Epilepsy
- Seizure
- Age specific cognitive/memory or confusion problem (T)
- Other:

EENT

- No Previous Hx.
- Visually impaired
- Right
- Left
- Blind
- Hearing impaired
- Right
- Left
- Deaf
- Right
- Left
- Sinus problem
- Multiple ear infections
- Frequent sore throats
- Deviated septum
- Tracheotomy
- Speech problems (T)
- Other:

PULM

- No Previous Hx.
- Asthma (T)
- COPD
- Pneumonia
- TB
- Bronchitis
- Short Of Breath
- Apnea
- RSV (Respiratory Syncytial Virus): Date of most recent RSV vaccine
- Home respiratory equipment use:
  - (T)
  - Other:

CV

- No Previous Hx.
- Congenital heart defect
- CP
- Murmur
- Heart failure
- Heart disease
- Cardiomyopathy
- Hypertension
- PVD
- Irregular heart beat
- Other:

GI

- No Previous Hx.
- Diarrhea
- Constipation
- Colitis
- Pancreatitis
- GERD
- Diverticulitis
- Ostomy (T)
- Chewing/swallowing difficulties
- Ulcers
- Liver disease
- Hernia, type
- Eating disorder
- Special diet:
  - Questions/difficulty following (T)
  - Other:

GU

- No Previous Hx.
- Diapers
- Bedwetting
- Kidney stones
- Bladder infections
- Testicular problems
- Kidney disease/failure
- Dialysis hemo/peritoneal
- Unusual bleeding
- Other:

REPRO

Female: [ ] No Previous Hx.
- Menses started
  - Yes
  - No
- Any unusual bleeding
  - Yes
  - No
- Sexually active
  - Yes
  - No
- Use of contraceptives
  - Yes
  - No
  - Type
  - Hx of STDS, Treated
  - Yes
  - No
- Pregnancies
  - # Pregnancies
  - Other:

Male: [ ] No Previous Hx.
- Self testicular exam
  - Yes
  - No
- Contraceptive use
  - Yes
  - No
- Hx of STDS, Treated
  - Yes
  - No
  - Other:

MS

- No Previous History
- Scoliosis
- Arthritis
- Fractures/bone problems
- Back/neck pain
- Mobility problems (T if recent):
  - Transfer
  - Balance standing
  - Gait
  - Other:

INTEG

- No Previous Hx.
- Non-healing or poorly healing wound (s) (WC):
  - Tattoo's location:
  - Other:

ENDOC

- No Previous Hx.
- Diabetes: (T)
  - type 1
  - type 2
  - Gestational
  - Unknown
  - Thyroid Abnormalities:
  - Hyper
  - Hypo
  - Other:

HEME

- No Previous Hx.
- Bleeding/clotting problems
- Sickle cell disease/trait
- Anemia
- Lead exposure
- DVT
- Bruise easily
- Transfusion: Date of last Reaction
  - Yes
  - No
  - Other:

ID

- No Previous Hx.
- Hepatitis (circle type) A, B, C
- AIDS
- HIV
- VRE (T)
- TB
- MRSA (T)
- Other:

CA

- No Previous Hx.
- Type:
- Year:
- Location:
- Current treatment:
- Other:

Date/Initial/Time: ___________________ ___________________ ___________________
GUIDELINES:

1. Indicate the correct facility with a ✓ check mark, page 1, upper left corner.

2. Documentation Methods - Questions are formatted to require one of the following methods of documentation. The two formats of questions are multiple choice and fill in the blank and allow for three methods of documenting a response:
   a. Circle appropriate response - Y (yes) or N (no) and multiple choice where "circle" is indicated next to the question.
   b. ✓ Check Mark - for multiple choice question where a box is preceding or immediately after the question.
   c. Fill in the Blank - complete the answer asked by putting the patient's response to the question on the line provided.

3. (T) (Trigger) This symbol indicates that an interdisciplinary referral may be appropriate based upon the response to the question. Please refer to the regional policy related to interdisciplinary referrals/triggers to identify practice and appropriate department where the referral should be sent. NOTE: many triggers require a physician's order before the referral can be completed.

4. Readiness To Learn Barriers
   Barriers to learning are assessed/identified throughout the content of the Admission Database questions. These barriers are found within the following question/areas: communication, current deficits, and assistive devices/items needed by the patient to perform activities of daily living and any medical equipment necessary to function.

5. ER is responsible for initiating page 1 of this form, pages 2 and 3 are completed when the patient is admitted to an inpatient area. Anyone entering data on this form must complete the date/initial or signature section on the bottom of page 3 or initial this section when using a signature profile.

6. Allergy Documentation - Enter all allergy information into the computerized medical record (Cerner), then print 2 copies of the "Allergy Report" form. This form when printed is titled "Allergy Report". One copy is to be placed in the patient's chart and the second copy is sent to the pharmacy if they have a different computer system to ensure documentation of allergies into the pharmacy computerized system. For computer downtime documentation allergies will be listed on the regional allergy form.

7. Home Medication Documentation - Home medications are to be listed on the Home Medication Profile and Discharge Medication Order Sheet.