

Carelink Health Care Services, LLC

Re-admission Nursing Reassessment Page 1	Patient's Name _____ History Given by _____ Date _____		
Current Diagnosis/Chief Complaints:			
History/Developmental Milestones			
Allergies: (environmental, drugs, food, etc.)			
Immunizations: (Mark all that apply) ☐ NA-no immunizations ☐ Hepatitis: Type ____ (A/B/C) ____/____ (Mo/Yr) ☐ Flu ____/____ (Mo/Yr) ☐ Tetanus/Diphtheria ____/____ (Mo/Yr) ☐ Pneumonia ____/____ (Mo/Yr) ☐ Other: ____/____ (Mo/Yr) Comments: _____			
Vital Signs: Temp. _____ Resp. _____ BP (designate position/s) _____ Pulse: Apical Rate _____ Radial Rate _____ Rhythm _____ Quality _____ Comments: _____			
Life System Profile 5-WNL 4-Not Normal, but w/o help 3-Uses a device 2-With assistance 1-Device and help 0-Dependent <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Activities of Daily Living (ADL) ____ Bathing ____ Transferring ____ Dressing ____ Locomotion ____ Grooming ____ Eating ____ Toileting ____ Other: _____ </td> <td style="width: 50%; vertical-align: top;"> Instrumental Activities of Daily Living (IDAL) ____ Telephone ____ Money management ____ Meal preparation ____ Shopping ____ Housework ____ Manage appointments ____ Laundry ____ Access resources ____ Medicine management ____ Transportation </td> </tr> </table>		Activities of Daily Living (ADL) ____ Bathing ____ Transferring ____ Dressing ____ Locomotion ____ Grooming ____ Eating ____ Toileting ____ Other: _____	Instrumental Activities of Daily Living (IDAL) ____ Telephone ____ Money management ____ Meal preparation ____ Shopping ____ Housework ____ Manage appointments ____ Laundry ____ Access resources ____ Medicine management ____ Transportation
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Homebound Status (✓ appropriate blanks) ☐ Outdoors without assistance ☐ Outdoors with assistance ☐ Confined to house, not bed disabled ☐ Bed disabled Comments: _____	Financial/Legal (✓ appropriate blank) ☐ Independent ☐ Needs assistance from _____ ☐ Power of Attorney ☐ Living Will ☐ DNR discussed Comments: _____		
Habits: (✓ and describe) ☐ Alcohol ☐ Nicotine ☐ Caffeine ☐ Street Drugs ☐ Sleep disorder ☐ Other Comments: _____			

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Patient's Name _____

Date _____

Psycho-Social Profile: ☐ No problems (leave blank) S-subjective problem D-objectively assessed problem

☐ Hx of previous psych. Illness	☐ Mood-depression/mania/liability	☐ Anxiety/agitation
☐ Memory loss-short term/long term	☐ Poor judgment	☐ Behavior problems
☐ Disorientation time/place/person	☐ Hallucinations/delusions	☐ Learning disabilities
☐ Communication barriers	☐ Emotional response to illness and care, body image	☐ Growth and development
☐ Interpersonal relationships	☐ Socialization	☐ Ethnicity

Comments: _____

Review of System/Physical Assessment: ☐ No problems (leave blank)

S-subjective problem O-objectively assessed problem DNA- for did not assess

Head

☐ Dizziness
☐ Headache

☐ Vision loss (chose one)
☐ Minimal
☐ Moderate
☐ Severe
☐ Blind
☐ Not Determined

Mouth

☐ Gum problems
☐ Chewing problems
☐ Dentures upper – lower - both

Eyes

☐ Glasses
☐ Blurred/double vision
☐ Change in vision (1 year)
☐ Glaucoma
☐ Cataracts
☐ PERRL

Nose

☐ Epistaxis

Ears

☐ Hearing loss (circle one)
☐ Minimal
☐ Moderate
☐ Severe
☐ Deaf

☐ Hearing aid
☐ Tinnitus

Neck and Throat

☐ Hoarseness
☐ Difficulty Swallowing

Comments: _____

Cardiovascular

☐ Palpitations
☐ Varicosities
☐ Chest pain
☐ Murmurs
☐ Pacemaker

☐ Dyspnea on exertion
☐ Claudication
☐ Fatigues easily
☐ Edema

☐ BR problems
☐ Paroxysmal nocturnal dyspnea
☐ Orthopnea; # pillows _____
☐ Cyanosis

☐ WNL

☐ DNA

Comments: _____

Respiratory

☐ Shortness of breath
☐ Shape and symmetry

☐ Wheezing
☐ Cough

☐ Sputum
☐ Breath sounds

☐ Oxygen
☐ Other

☐ WNL

☐ DNA

Comments: _____

Gastrointestinal Track

☐ Indigestion
☐ Nausea, vomiting
☐ Ulcers

☐ Pain
☐ Hernias
☐ Diarrhea/constipation

☐ Rectal bleeding
☐ Hemorrhoids
☐ Gallbladder problems

☐ Jaundice
☐ Tenderness
☐ Ostomy

☐ WNL

☐ DNA

Comments: _____

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Patient's Name _____

Date _____

Nutritional Status

☐ Weight loss or gain last 3 months (amount _____)

Height _____

Fluid intake amt/frequency _____

☐ Change in appetite

Weight (actual) _____ (reported) _____

Diet _____ meals prepared by _____ times per day/wk

Comments: _____

Genitourinary Tract

☐ Frequency

☐ Nocturia

☐ Dysmenorrhea

☐ Gravida/Para

☐ Pain

☐ Urgency

☐ Lesions

☐ Date last PAP test

☐ Hematuria

☐ Vaginal discharge/bleeding

☐ Prostate disorder

☐ Contraception

☐ Incontinence

☐ Hx hysterectomy

☐ WNL

☐ DNA

Comments: _____

Breasts (for both male and female)

☐ Lumps

☐ Tenderness

☐ Discharge

☐ Pain

☐ Does Self-breast exam

☐ WNL

☐ DNA

Comments: _____

Integumentary

☐ Hair Changes

☐ Pruritus

☐ Color

☐ Turgor

Skin Condition (Record code # on body area.
Indicate size to right of numbered category.)

1 Lesions

2 Bruises

3 Masses

4 Incisions

5 Scars

6 Ulcers

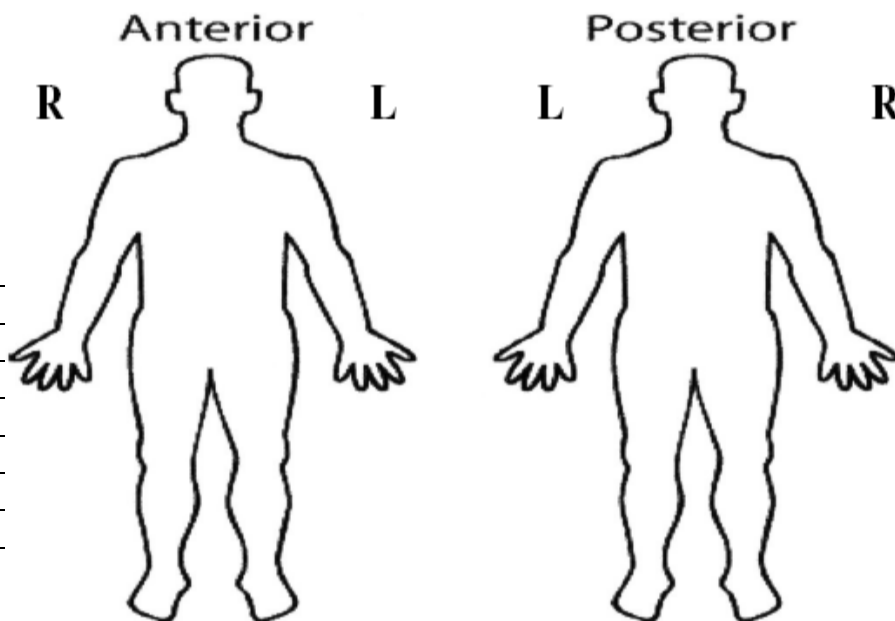
7 Decubiti

8 Pressure areas

☐ WNL

☐ DNA

Comments: _____



Musculoskeletal, Neurological

☐ Stiffness

☐ Leg cramps

☐ Seizure

☐ Paralysis

☐ Swollen joints

☐ Numbness

☐ Tenderness

☐ Amputation

☐ Coordination

☐ Unequal grasp

☐ Deformities

☐ Tremor

☐ Joint pain

☐ Gait

☐ Temp changes

☐ Aphasia/inarticulate speech

☐ Weakness

☐ Syncope

☐ Balance

☐ Comatose

☐ WNL

☐ DNA

Comments: _____

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Patient's Name _____

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Endocrine and Hematopoietic

- ☐ Polyuria ☐ Excessive bleeding or bruising ☐ Intolerance to heat and cold
☐ Polydipsia ☐ Skin texture ☐ Excessive perspiration
☐ WNL ☐ DNA

Comments: _____

Pain Status

Frequency of Pain interfering with patient's activity or movement:

- ☐ Patient has no pain or pain does not interfere with activity or movement
☐ Less often than daily
- ☐ Daily, but not constantly
☐ All of the time

Comments: _____

Non-Verbal Patient Pain Assessment: (Mark all observed or reported behaviors that may be pain related)

- ☐ None Reported/Observed ☐ Restlessness ☐ Rigidity ☐ Crying
☐ Facial Grimaces ☐ Guarding ☐ Moaning ☐ Other

Comments: _____

Does pain impact patient's daily functioning?

- ☐ Yes ☐ No

Comments: _____

Ask patient if they take any OTC oral or topical meds (such as NSAID's, Ben-Gay etc.) and/or herbal remedies to obtain pain relief. Add all OTC/Herbal meds to Medication List.

Number each site of the patient's pain and describe using scales, etc. below.

Intensity

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe

Characteristics: A-Ache (Dull) B-Burning C-Crushing R-Radiating S-Sharp T-Throbbing O-Other (describe)_____

Location of Pain: _____

Current Relief Methods (Oral meds, ice, elevation, other) _____

Goal: (0-10)_____

Comments: _____

Goal/Plan

Patient Signature _____ Date _____

Nurse Signature _____ Title: _____ Date _____