**Admission care Evaluation record**

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| Name： | | gender： | | | age： | Ward： | | | Bed No： | | Hospital number： | |
| 1、**normal information** | | | | | | | | | | | | |
| Family social situation： | | | Career： | | | Educational level： | | | marital status：unmarried married other： | | | |
| contact address： | | | | | | | Contact and phone number： | | | | | |
| Admission date： | | | | | | | People's way：walk wheelchair Flatcar other： | | | | | |
| Reason for admission： | | | | | | | | | | | | |
| Admission diagnosis： | | | | | | | | | | | | |
| Past history： hypertension heart disease diabetes Cerebrovascular disease History of surgery Mental illness other： | | | | | | | | | | | | |
| allergies： no Have drug： food： other： | | | | | | | | | | | | |
| 2、**Nursing assessment** | | | | | | | | | | | | |
| T: ℃ | P： Times/minute | | | | | R： Times/minute | | BP: mmHg | | | | 体重： kg |
| consciousness：clear Sleepiness Ambiguous lethargy Light coma Deep coma dementia | | | | | | | | | | | | |
| expression：normal indifferent pain tension | | | | | | | | | | | | |
| mood：stable Irritability tension fear anxiety Depression despair | | | | | | | | | | | | |
| vision：normal Lack of vision blindness other | | | | | | | | | | | | |
| hearing：normal Hard listening Deafness other | | | | | | | | | | | | |
| Communication skills： normal low Unable to communicate | | | | | | | | | | | | |
| Communication method： Language Text gesture other | | | | | | | | | | | | |
| Comprehension： good general difference | | | | | | | | | | | | |
| Oral mucosa： normal Congestion damaged Mold infection ulcer | | | | | | | | | | | | |
| Denture：no have | | | | | | | | | | | | |
| skin：normal Edema jaundice pale Hair clamp rash Bruise Itching | | | | | | | | | | | | |
| Pressure sore：no have Part range | | | | | | | | | | | | |
| Limbs：normal hemiplegia disfunction Lower extremity edema other | | | | | | | | | | | | |
| Excretion：Pee：normal incontinence Urinary frequency Little urine Urgency Urinary pain Urinary retention Urethral stoma other | | | | | | | | | | | | |
| Stool：normal incontinence constipation Black stool Stoma | | | | | | | | | | | | |
| diarrhea： Times/day other | | | | | | | | | | | | |
| ADL score： Braden score： Morse: Pipe slip score： | | | | | | | | | | | | |
| Body type：normal obesity thin Cacao | | | | | | | | | | | | |
| diet：normal：salty、sweet、Spicy、Greasy、Light、other ，Not eating  abnormal：Loss of appetite hard to swallow Chewing hard feel sick and vomit | | | | | | | | | | | | |
| living habit：Smoking：no yes Branch/day Drinking：no yes g/day  Sleep：normal Difficulty falling asleep Dream more Easy to wake up，Daily sleep hours  Drug-assisted sleep：no yes drug | | | | | | | | | | | | |
| Family attitude：care not care Too concerned Unattended Not cooperating | | | | | | | | | | | | |
| 1. **Admission to mission**   Bed doctor Responsible nurse Ward environment Ward system Visit rules and time Safety guidance Meal arrangement Psychological counseling Prohibit going out Wristband wear  other | | | | | | | | | | | | |
| 4**、Care plan** | | | | | | | | | | | | |
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| Evaluation time： | | | |  | | | Nurse signature： | | |  | | |