RiverValley Behavioral Health Hospital

Admissions Prescreening Assessment

NAME:
DOB
AGE
ACCOMPANIED BY:
DATE
TIME

REFERRAL INFORMATION
Primary Care Doctor:
Location:
Referred By:
Phone:
Reason for Referral:

NURSING ASSESSMENT
TB Questionnaire
History of exposure to TB:
Date and results of last TB skin test:
Documentation as time of admission ☐NO ☐YES
If last skin test positive: Date of last CXR:
Date prophylactic meds completed:
Circle present symptoms:

Other:
Breath Sounds:

CURRENT HEALTH CONDITIONS
Health Condition:
Treatment/Medication for condition
Have treatments/meds been given as prescribed in last 72 hours? ☐YES ☐NO If no, state why:

CURRENT HEALTH STATUS
Medication & Food Allergies:
If female, LMP:
If pregnant, EDC:
Vital Signs:
Temp:
Pulse:
Resp.:
BP:
Other:
Obvious wounds or s/s of health care needs:

Pain Screening (circle one) ☐ 1 ☐ 2 ☐ 3
Location of pain:
What is done for report of pain?

CURRENT MENTAL STATUS
Orientation status:
time
date
place
person
situation
alert

ASSESSMENT SUMMARY
Medically stable for admission:
YES If yes, patient must be searched before unit admission. Admitted to Room:
NO If no, state why:

If not medically stable for transfer or admission, contact physician on call for instructions. If life threatening emergency, call 911.

Physician contacted:
Time:
Instructions:
State treatment provided:

Nurse Signature:
Date:
Time: