UNIT WARD BED)	(= <u></u>	
uvaical 21 5			VIN
uvaical 21 5	_	LEE HO S913657	2D
2.5.2.	· · · · · · -		Clementi Ave 4, S 650648
		RUCTIONS	
and plan of care are done within 2	4 hours of patient's admi		
2 The Integrated Nursing Record sha	all be used to assess and	d plan the appropriate nursing care for all	patients.
3 The plan of care is based on Abde process of assessment, planning,	llah's Model of 21 Nursir implementation and eval	ng Problems and patient care is planned i luation	using the nursing
4 For sections where boxes are used	d, place a∕tick i⊟he	where applicable.	
ORIENTATION : To be completed	l by PCA and above		
ERSON TO CONTACT IN EMERGENC		· · ·	
NAME	RELATIONSHIP	CONTACT NUMBERS	LANGUAGE SPO
pokesperson 1		(Res) 6.744>196	English
Teo Hock Long	Som	(Off) 67607311 (HP) 81541719	Mandavi. English
Spokesperson Z		(Res) 67499157	English
Teo Pon Ann.	Daughter.	(HP) 98971433	Mandarin
Caregiver 1		(Res)	
		(Off) :	
Caregiver 2		(Res)	
		(Off)	
	1	(HP)	-
2 ADMISSION DATA	; - ;		
Police Case No	☐Yes	Industrial Accident No 2	
Time of arrival 11-30 hrs	Doctor informed 1/2	30 hrs Seen by	doctor 1150 hrs
A&E	. □sc	☐ Others	
Promi		□ Walk in	
Oit DEscrip	. Family	☐ Others	
With Li Friend			
Preferred Spoken Language:	☐ Malay	□ Tamil	
Dialect/Others(specify):			
		New case of CH	•

	The second secon
PATIENT ORIENTATION CHECKLIST	
ontation Given To: Patient Family membe	r - Others: (Please Specify):
✓ Ward Layout ✓ Ward Routine	
7	ods by doctors
Use of call bell Medicatio	
● Emergency exits ● Meal time	
1 Parks with the	
Location or light switches not applicable Bathroom & tollets for ICU and HD	
• Baumoun & toners	
Hospital Routine Patient Faciliti	es Personal Belongings
 Permission before leaving ward Day room. 	Responsibility for valuables
 To remain in hospital till discharge ■ Telephone 	▼ Tolletries
 ✔ Visiting hours ★ Television 	
Hospital check-out time Air-conditions	oning
Others Places engelful	
Others (Please specify):	
PERSONAL ITEMS (Personal Items kept in ward for use at own risk)	
No (If no, go to point 7)	\sim
Yes	
Martin and Chapter	Minist weeksh
Vision aid	⊠ Wrist watch
Contact lens, specify	
	71
Hearing aid O Specify	☐ Handphone
Denture O Specify MRIRY J Lower Gull	☐ Others
Denture O Specify MRIPLY Lower (full Set)	Services 1
Walking device With patient	
Whitelchair	
☐ Quad stick	
☐ cluad suck	
· · · · · · · · · · · · · · · · · · ·	
☐ Others (specify)	
A PROPERTY OF PERSONAL PROPERTY.	
SAFEKEEPING OF PERSONAL PROPERTIES	
No Identity Card or property received	
RECEIVED property for safekeeping, document in PROPERTY FORM	
LADATION	
EARATION I have been orientated through the details above and understand the information pr	ovided by the attending purse
I understand that if I / the patient choose to keep any valuables or cash with me / his	m / her during hospitalisation,
I shall not hold ' CLEMENTI Hospital responsible in any way in the event of loss	or damage to the valuables / cash.
117.6 05.11	
ce given to: HENG PAN YUI O	<i>i</i>
Name Sign	ature Relationship
ce given by: AMY CHUA	€
	eature Designation
Section A assessed by:	
	≥ 11:35
and EN AMY CHUA	"
and EN AMY CHUA Designation Name	Signature Date Time
	"

	CTION A: Complete within 4 hours of admission by EN and above	
9	COGNITION / PERCEPTION PATTERN	
a)	Level of consciousness: ☐ Alert ☐ Confused ☐ Drowsy ☐ Unresponsive ☐ Disorientated	
	Orientated to: Day D'Time. Person Place	
	Official and the second of the	• •
ь)	Sensory; ☐ Asymptomatic ☐ Dizziness. ☐ Headache ☐ Numbness	
Β)		
, .	District and the second	
c)	treating.	
d)	Vision: Right ☑ Normal ☐ Impaired (specify) ☐ Unable to assess	
,	Left: Normal Impaired (specify) Unable to assess	
	Remarks	
10	RESPIRATION	
	Breathing pattern Presence of symptoms:	
	☑ Regular ☐ Irregular ☐ Nil ☑ Dyspnoea ☐ Cough ○ Productive ○ Haemoptys	sis
'	12 14 100 18 15 45 AC 28 - WILL CAR SUR	
	Remarks 41 gft 4013 Vaspindia nate 28-30/m. Spor (RA) 9490-	
11		
<u>'</u>	Pulse Presence of symptoms:	
١.	□ Regular □ Irregular □ Nil □ Chest pain □ Chest tightness □ Giddiness □ Codema	3
	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	
	Extremities	
	□Warm □ Cold □ Clammy □ Cyanosed	
	Remarks	
12	PAIN/COMFORT	
	Presence of Pain Mark a cross (X) or shade the affected areas	s
Γ.		
	— 1.0 (1 1.0) So 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	☐ No, pain resolved after treatment at A&E. Complete pain assessment	
1	Yes. Complete pain assessment	Taxable Sales
•		Parket Monte Control
	☐ Yes. Complete pain assessment ☐ Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal /	Baywara was a second
	Yes. Complete pain assessment	Transference and the second
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients"	Particular and Partic
а	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients"	The state of the s
a	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hurt? Will gading refer The gading refer to "Pain Assessment Protocol in Non-verbal / Location of Pain: Where does it hurt?	Contractive designation of the Contractive
a	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hurt? Will gading refer The gading refer to "Pain Assessment Protocol in Non-verbal / Location of Pain: Where does it hurt?	Appropriate the second of the
a. b.	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal." Non-communicative Patients Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. R	production and the second second second second second second second second second
a b c	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hurt? Wigadial region	Particular Particular Control of the
a. b. c.	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR	principal and the second section of the second seco
a. b. c. d	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal." Non-communicative Patients Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR	THE PROPERTY OF THE PROPERTY O
a. b. c. d	Pain Assessment Location of Pain: Where does it hun? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR Duration: How long have you had this pain? (hours / days / months / years)	Complete and an analysis of the second secon
a b c d	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR Duration: How long have you had this pain? (hours / days / months / years) Verbal Numerical Pain (VNP) Scale	Control of the Contro
a b c d	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal." Non-communicative Patients Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR Duration: How long have you had this pain? (hows / days / months / years) Verbal Numerical Pain (VNP) Scale	The state of the s
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR Duration: How long have you had this pain? (hours / days / months / years) Verbal Numerical Pain (VNP) Scale	N. S. J. S.
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR Duration: How long have you had this pain? (hours / days / months / years) Verbal Numerical Pain (VNP) Scale	Management of the second secon
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients' Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR Duration: How long have you had this pain? (hours / days / months / years) Verbal Numerical Pain (VNP) Scale Quality: Is the pain constant, dull, sharp, burning or on and off? Constant at dull Simple Pain Descriptive (SPD) Scale	Management of the state of the
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal." Non-communicative Patients Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale. Tick scale used VNP SPD FPR Duration: How long have you had this pain? (hows / days / months / years) Verbal Numerical Pain (VNP) Scale Quality: is the pain constant, duil, sharp, burning or on and off? Constant of duil. Simple Pain Descriptive (SPD) Scale Does your pain affect your usual daily routine?	
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients' Pain Assessment Location of Pain: Where does it hurt? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale 7 R Tick scale used VNP SPD FPR Duration: How long have you had this pain? (hours / days / months / years) Verbal Numerical Pain (VNP) Scale Quality: Is the pain constant, dull, sharp, burning or on and off? Conctant at dull Does your pain affect your usual daily routine? No Pes	Commence of the contract of th
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Lication of Pain: Where does it hurt? Wigath Larger	The state of the s
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hur? Location of P	production of the control of the con
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative patients" Pain Assessment Location of Pain: Where does it hun? Wilgard Verbal Numerical Pain (VNP) SPD FPR Duration How long have you had this pain? (how / days / months / years)	purious in the superminant of th
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Location of Pain: Where does it hur? Location of P	The state of the s
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Pain Assessmen	The state of the s
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Potocol in Non-verbal / Non-communicative Patients Pain Assessment Location of Paint: Where does it hur? Location of Pai	The state of the s
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Protocol in Non-verbal / Non-communicative Patients Pain Assessment Location of Pain: Where does it hurt? Location of Pa	
	Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Lication of Pain: Where does it hur? Example 1 Example 2 Example 2 Example 3 Pain Assessment Lication of Pain: Where does it hur? Example 2 Example 3 Pain Assessment Lication of Pain: Where does it hur? Example 2 Example 3 Pain Assessment Protocol in Non-verbal / Non-communicative Patients Pain Assessment Protocol in Non-verbal / Non-verbal / Non-verbal / Pain Assessment Protocol in Non-verbal / Non-verbal / Pain Assessment Protocol in Non-verbal / Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Protocol in Non-verbal / Pain Assessment Pain Assessment Protocol in Non-verbal / Pain Assessment Pain Assessment Protocol in Non-verbal / Pain Assessment Pain Assessment Pain Assessment Protocol in Non-verbal / Pain Assessment Pain Assessment Protocol in Non-verbal / Pain Assessment Pain Asse	The state of the s
e	Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative patients" Pain Assessment Location of Pain: Where does it hurr? Location of Pain: Verbal Numerical Pain (NP) Scale Location	_
e t	Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative patients" Pain Assessment Location of Pain: Where does it hunt? White does it hunt? White does it hunt? Pain Assessment Pain Severity Score: How bad is the pain? Use only ONE pain scale The pain Pain Severity Score: How bad is the pain? Use only ONE pain scale The pain	ıe
e t	Non-communicative patient, refer to "Paln Assessment Protocol in Non-verbal / Non-communicative patients" Paln Assessment Location of Pain: Where does it hurt?	ıe

14	CTION B:Complete within 24 hot assessment of Diabetes		LEE HO YIN S23154791 Blk 648, Clementi Ave 4, WD _ 21 _ BED _ 5
	Questions	1	Response Score Score
a	History of diabetes		No (go to item 15)
		0	Yes
р.	Newly diagnosed diabetes	10	√ No 0
٠.			Yes 4
c	On oral diabetes medication or INSULIN	: 02	No 0.
	therapy		Yes, please specify: O Tablet 1
•			O Insulin(with or without lablets) 4
d	Previous or current problem with FEET	Ø	No D
			General complaints (numbness, lingling sensation/pin and needles) 1
			Active ulcers / Previous amputation 4
	Patient is admitted for Hypoglycaemia	Ø	No 0
-	7		Yes 4
. 1	IF TOTAL SCORE IS ≥ 4:		
	Fax "Assessment of Diabetes" section to Dia	betes l	Nurse Total Score O
	For ICU or HD patients, fax "Assessment of D		
ъj	For 100 of 110 patients, tax Processing 11 of 1		
-	Remarks		
	NUTRITIONAL SCREENING (Complete the sc	roanin	on by ficking as appropriate)
15	Nutritional indicator	·	Status Yes No
_		onthi or	over the past 3 months due to loss of appetite,
	Food Intake digestive problems	e.g. v	vomitting, chewing or
_			
•	Mode of feeding Tube feed		
· 	Mode of feeding Tube feed		
		ht loss	s greater than 3kg (6.6lbs) during last 3 months
		ht loss	
			s greater than 3kg (6.6lbs) during last 3 months
	Weight loss Unintentional weig	sores .	s greater than 3kg (6.6lbs) during last 3 months
	Weight loss Unintentional weig	sores multipl	s greater than 3kg (6.6lbs) during last 3 months
	Weight loss Unintentional weight Diet-related condition Wounds / pressure (may tick more than one) Multiple trauma or Signs of muscle w	inultipl	s greater than 3kg (6.6lbs) during last 3 months
	Weight loss Unintentional weight loss Unintentional weight loss Wounds / pressure may tick more than one) Multiple trauma or Signs of muscle where / post major st	inultipl	s greater than 3kg (6.6lbs) during last 3 months Discrete fractures / cachexia eg. Abdominal, ENT surgery and others
	Weight loss Unintentional weight loss Unintentional weight loss Unintentional weight loss Wounds / pressure Multiple trauma or Signs of muscle w Pre / post major st Sepsis / infection	inultipl	s greater than 3kg (6.6lbs) during last 3 months s clinical state of the fractures / cachexla eg. Abdominal, ENT surgery and others
	Weight loss Unintentional weig Diet-related condition (may tick more than one) Wounds / pressure Multiple trauma or Signs of muscle w Pre / post major st Sepsis / infection Cancer	sores multipli asting / argery e	s greater than 3kg (6.6lbs) during last 3 months
	Weight loss Unintentional weig Diet-related condition Multiple trauma or Signs of muscle w Pre / post major st Sepsis / infection Cancer Gastrointestinal di	a sores multipli asting / argery e	s greater than 3kg (6.6lbs) during last 3 months
	Weight loss Unintentional weig Diet-related condition Multiple trauma or Signs of muscle w Pre / post major st Sepsis / infection Cancer Gastrointestinal di	a sores multipli asting / argery e	s greater than 3kg (6.6lbs) during last 3 months is a
	Weight loss Unintentional weig Wounds / pressure (may tick more than one) Multiple trauma or Signs of muscle w Pre / post major st Sepsis / infection Cancer Gastrointestinal di Therapeutic diet e.	a sores multipli asting / argery e	s greater than 3kg (6.6lbs) during last 3 months s c) cle fractures / cachexia eg. Abdominal, ENT surgery and others C C C C C
	Weight loss Unintentional weig Diet-related condition Multiple trauma or Signs of muscle w Pre / post major st Sepsis / infection Cancer Gastrointestinal di	a sores multipli asting / argery e	s greater than 3kg (6.6lbs) during last 3 months Comparison
	Weight loss Unintentional weig Wounds / pressure (may tick more than one) Multiple trauma or Signs of muscle w Pre / post major st Sepsis / infection Cancer Gastrointestinal di Therapeutic diet e.	a sores multipli asting / argery e	s greater than 3kg (6.6lbs) during last 3 months
	Weight loss Unintentional weig Wounds / pressure (may tick more than one) Multiple trauma or Signs of muscle w Pre / post major st Sepsis / infection Cancer Gastrointestinal di Therapeutic diet e.	a sores multipli asting / argery e	s greater than 3kg (6.6lbs) during last 3 months s cle fractures / cachexla eg. Abdominal, ENT surgery and others

		CTION A: Complete within 4 hours of admission by EN and above
2-2-2	SEC	TION A: Complete within 4 hours of authoritor by Extend users
" - [-	COGNITION PERCEPTION PATTERN Confused □ Drowsy □ Unresponsive □ Disorientated
.,	a)	Level of consciousness:
		Orientated to: Day Time Person Place
. :		Sensory: △ Asymptomatic □ Dizziness □ Headache □ Numbness
	b)	
		□ Paralysis. □ Tingling □ Tremors
	c)	Hearing: Right ☑ Normal ☐ Impaired (specify) ☐ Unable to assess
		Left □ Normal □ Impaired (specify) □ Unable to assess
İ		Vision: Right Normal Impaired (specify) Unable to assess
.	a)	Vision: Right A Normal Impaired (specify) Unable to assess
		Remarks
ł	10	RESPIRATION
		Breathing pattern Presence of symptoms:
		☑ Regular ☐ Irregular ☐ Nil ☑ Dyspnoea ☐ Cough ○ Productive ○ Haemoptysis
		O Non productive
.		Remarks sight 50B Vagendrin rate 28-30/m. Spor(RA) 94%.
.		Remarks Stages 7017 passyrvas 7100 (144) 1770
	11	CIRCULATION
. :	11	The same of proportions:
,	\sim	Taris T Chart sein T Chart fightness T Giddiness Thedema
		Regular Z Irregular LINII LI Chest pain Li Chest ughturess Li chadiness 52 5555000
		Extremities
		□Warm □ Cold □ Clammy □ Cyanosed
٠,	ļ	Remarks
	12	PAIN / COMFORT Presence of Pain Mark a cross (X) or shade the affected areas
•	١.	
	١٠.	□ No (If no, go to item 13) on the body diagram below:
٠.		☐ No, pain resolved after treatment at A&E. Complete pain assessment
		(2) Yes. Complete pain assessment
		□ Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal /
	ł	Non-communicative Patients*
٠, ,٠.	ļ	
		Pain Assessment
	a	Location of Paint: Where does it hunt? Epigadric regime
	1 :	
	p	PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale: 7 R) (L) (R)
	·	Tick scale used ✓ VNP □ SPD □ FPR
•	, c	Tick scale used ☑ VNP □ SPD □ FPR
	1	Duration: How long have you had this pain? (hours / days / months / years)
	d	
*		Verbal Numerical Pain (VNP) Scale
	ė	Quality: Is the pain constant, dull, sharp, burning or on and off?
	1	and to death
	'	Simple Pain Descriptive (SPD) Scale
	1:	Does your pain affect your usual daily routine?
٠.	I	Does your pain aneut your assert daily footile.
	'	□ No □ Yes ○ Performs ADL with discomfort ○ Mild pain 2
٠,	1.	Interferes with ADL and sleep Moderate pain 5
٠.		Willesteles with ADE and Good
		Oduleis
		Faces Pain Rating (FPR) Scale
	1	Markett Higher House and S 100
	-	
	1	Section A assessed by:
	13 EN	Section A assessed by: IFN AMY (Hua III)
	1	Section A assessed by: I FN APMY (HLA Signature Time Name Signature Time
	1	Section A assessed by: I FN AMY (H4A III) Designation Name Signature IIme Designation Name Signature IIme

The state of the s	
7 ORAL CAVITY	
Mouth / Tongue: ☐ Moist , ☑ Dry , ☐ Coated ☐ Ulcer	.
Teeth: Intact Loose (specify)	
Dentures Oupper Olower	.
Presence of Nil Nausea Difficulty in swallowing	
Presence of: Nil Nausea Lyvomiting Dillicatly in swallowing	.:. .·
	1
Remarks	-
B SKIN	:
Colour: Integrity	-
☐ Normal ☐ Flushed ☐ Jaundiced ☐ Intact ☐ Impaired Description ☐ Site(s) (Specify)	1
The state of the s	
Others (Specify): Superficial broken skin	
P. Davies	
Body Jemperature	
Normal Podposs	
Subnormal body temperature	-
Raised body temperature	ı
Dataselo	ć
Remarks	
RESSURE ULCER RISK ASSESSMENT: BRADEN SCALE	· ,
Braden scale criteria Descriptors Score	4
ensory perception 1. Completely limited 2. Very limited 3. Slightly limited 4. No impairment 3.	\downarrow
oisture 1. Constantly moist 2. Moist 3. Occasionally moist 4. Rarely moist 3.	4
stivity 1. Bed bound 2. Chair bound 3. Walk Occasionally 4. Walk frequently 3.	_
oblity 1. Immobile 2. Very limited 3. Slightly limited 4. No limitation 3	\dashv
utrition 1. Very poor 2. Probably adequate 3. Adequate 34. Excellent Z Fin	
ction and sheer 1. Problem 2. Potential problem 3. No apparent problem 3. Ch	
Total score 16 12 Ek	_ د
SCORE IS ≤16 → Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for	١.
Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care)	
Flessure Dicel and impalent outricer rates fracting rouse and that a series	
	•
Remarks	
	4
9. ELIMINATION	
Urinary	
Appearance: Presence of:	
Clear Cloudy Haematuria Cloubling Frequency Incontinence	: 1
☐ Tea coloured ☐ Urgency ☐ Burning sensation ☐ Retention	.
☐ Others (specify)	
Adaptive aids:	ľ
`	
	-
☐ Urosheath ☐ Others (specify):	£
	. 1
	•]
☐ Urosheath ☐ Others (specify): Remarks	
☐ Urosheath ☐ Others (specify): Remarks Bowel	
☐ Urosheath ☐ Others (specify): Remarks	.
□ Urosheath □ Others (specify): Remarks Bowel Usual bowel pattern (specify) 1 × 2ex 2-3 day 5 .	
Urosheath Others (specify): Remarks Bowel Usual bowel pattern (specify) 1 × 2ey 2-3 day 5 Problem of:	

	FUNCTIONAL STATUS				f
	✓ tick on the appropriate box	. =	e e e e e e e e e e e e e e e e e e e	· · · · · · · · · · · · · · · · · · ·	
	New onset difficulty with the following;	No .	Yas	If yes, automatic referral (except for ICU & HD cases trauma and RTA cases)	, spinal injuries,
	Ambulation	J .:		Physiotherapist on	
	Tolleting / Bathing		-		
	Dressing / Grooming	<i></i>		Occupational Therapist on	
	Transfer			Occupational merapist on_	
	Feeding				
	Speaking	· V.		Speech Therapist on	· .
	Swallowing			Operation (nonapiet en	
	Remarks				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
•	ASSESS IN GENERAL WARD : Da	to Acrossed			
 -	FALL RISK ASSESSMENT			n No. 22 Sleep Pattern)	
	1 ALL MOR AGGLOGISTERS			,	<u> </u>
a:M	Mon	se Scale Criteria	· · · · · ·		Score (circle the number)
1	History of fall (include current admiss	sion and last 12 months)			No · · p
			· · · · · · · · · · · · · · · · · · ·	"	Yes 25 .
2	Has a secondary diagnosis e.g with	comorbidities, polypharma	ıcy		No 0
	(If more than 1 medical diagnosis	is listed)	•		Yes 15
3.	Receive: IV the hipy / heps	rin Lock		γ.	No 0
		· ·			Yes 20 .
4	Use Ambulatory Aid: None	a / bedrest / nurse assist			0
	• Crut	ches / stick / umbrella / qu	adstick / frame		` 15
	♥ Hold	s on to furniture	·	<u> </u>	. 30
5.	Galt is: • Norr	nal / bedrest / Wheelchair	<u> </u>	· · · · · · · · · · · · · · · · · · ·	
	● Wea	k .			70
	e Impa	aired			20
6.	Mental Status • Orie	ntated to own ability		·	. (9)
	• Ove	restimated / forgets limitati	ions		15
				Total Score	35
	* * * * * * * * * * * * * * * * * * * *		imant in Wiel/ Accecemen	ntior Halls and	, ,
- sc		fall precautions and docu		•	
- sc		fall precautions and docu Clinical Notes (Nursing Not			
= sc	inpatient C	•			
= sc		•			
	inpatient C	•			
	RemarksSLEEP PATTERN	Siinical Notes (Nursing Not	tes and Plan of Care)		
	inpatient C	Siinical Notes (Nursing Not	tes and Plan of Care)	insomnia O Others, specify	
	Inpatient C	Siinical Notes (Nursing Not	tes and Plan of Care)		
	RemarksSLEEP PATTERN	Siinical Notes (Nursing Not	tes and Plan of Care)		

	- WOULD DOUBAL DEACTION
23	PSYCHOLOGICAL REACTION
. ' '	No apparent problem Problem Sad
	Reaction ☐ Calm ☐ Anxious / Nervous ☐ Frequent crying / Tearful ☐ Withdrawn ☐ Imitable ☐ Sad
	☐ Aggressive ☐ Violent ☐ Angry
ł. i	Expressed
1 .	Tooling tired at all times
- 1	Count, Condition 42114-5
f .	☐ Difficulty in concentrating, remembering things or decision making
	☐ Others (specify)-
1.	If ≥ 1 tick, inform doctor and document in Inpatient Clinical Notes (Nursing Notes and Plan
1.	
1 .	of Care)
-	Remarks
24	SPIRITUAL / CULTURAL
	Religion
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.	7 Buddhism
	☐ Free thinker ☐ Islam ☐ Christianity ☐ Others
•	
	Any other concern
	Any concern related to disc
1	□ No □ Yes, specify Poor Affect ₹ □ No □ Yes, specify
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1	Remarks rapid weight loss 17/69 7 3 month's tre
	Remarks
o É	ECONOMIC & FINANCIAL SUPPORT
. 23	Children Children
1 .	Li Employer
1 .	☐ Public Assistance ☐ Relatives ☐ Friends ☐ Others
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	Remarks
26	S 'SOCIAL HISTORY'
26 a	S SOCIAL HISTORY Accommodation: With family, specify 500 Diversione Diversione Others (specify)
26 a	Accommodation: With family, specify 4 Live alone Others (specify)
a b	Accommodation:
a b	S SOCIAL HISTORY Accommodation:
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a b c d	SOCIAL HISTORY Accommodation:
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27 (i)	S SOCIAL HISTORY Accommodation:

	- WOULD DOUBAL DEACTION
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. ' '	No apparent problem Problem Sad
	Reaction ☐ Calm ☐ Anxious / Nervous ☐ Frequent crying / Tearful ☐ Withdrawn ☐ Imitable ☐ Sad
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1.	
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24	SPIRITUAL / CULTURAL
	Religion
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.	7 Buddhism
	☐ Free thinker ☐ Islam ☐ Christianity ☐ Others
•	
	Any other concern
	Any concern related to disc
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27 (i)	S SOCIAL HISTORY Accommodation:

		CHARGE CHECK	THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER.				
	Instruction	ns: To be completed on day	of discharge				
Date of discharge	Time						
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ischarge to:					· · ·		
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Node of charge:			•			• • •	
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☐ Discharge Memorandun	n (2 copies if patient is for STO /	/Dressing at Polyclinic)					
STO date :					• • •		
Types of dressing and o	iate due :	. ,					
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