		INTEGRATED N	URSING RECORD	
UNIT	WARD B	ED .		LEÉ NO VIN
	``			LEÉ HO YIN S3925683C
Surgical	- 21 5			Blk 648, Clementi Ave 4,
, ,		_	`	#03-723 S 650648
			TRUCTIONS	
1 The Reg	gistered Nurse is respon	sible to ensure that baseli	ne assessment is done within 4	hours and full assessment
		24 hours of patient's adm	n 10"•	
	- N		d plan the appropriate nursing o	
3 The plan	of care is based on Ab	dellah's Model of 21 Nursi	ng Problems and patient care is	planned using the nursing
		g, implementation and eva		
4 For sect	ions where boxes are u	sed, place a∕lick i⊟he	where applicable.	
ORIENTAT	ION : To be complet	ted by PCA and above		
	O CONTACT IN EMERGE			
ī. 	NAME	RELATIONSHIP	CONTACT NUMBE	RS LANGUAGE SPO
Spokesperson 1			(Res) 6.744>19	6. ,- ,- ,-
	11 1/ 100	Som	(Off) 6760731	1 English
120	Hock Long.	v	(HP) - 81541719	· Mandari
Spokesperson 2			(Res) 6545915	Mandavi Julinglich
· —	Pon Ann.	Daughter	(Off) 6720123	
. 120	THE PART .		(HP) 9897143	3. Mandari
Caregivar 1			(Res)	
			(Off)	·············
	 		(HP)	
Caregiver 2			(Res)	
			(Off)	
L.,		· 1 . · · · · · · · · · · · · · · · · ·	((1))	
2 ADMISS	ION DATA			
Police C	ase 🕡 No	□Yes	Industrial Accident	No Yes
Time of	arrival 11-30 hrs	Doctor informed !!	30 hrs	Seen by doctor 11:50 hrs
		1 8		
From	. √ZA&E	, □sc	☐ Others	-1
Οú	· Wheeld		□ Walk in	
With	□ Friend	. Dramily	Others	
	d Spoken Language:		,	, •
☐ Englis	.	rin 🗆 Malay	☐ Tamil	
	t/Others(specify):		New case of CH	
1	US ADMISSION :	· ·	, 1,51, adaptor of [5 72
	Old case of CH Trac	e casenotes on		

	užu 181
5 PATIENT ORIENTATION CHECKLIST	
orientation Given To: - Patient Family member - Others: (Please Specify):	
☐ Ward Layout ☐ Ward Routine	.] .
Bed number & side-ralls Ward rounds by doctors	
Use of call bell Medication times	٠ أ
	.
The second secon	
Location of light switches not applicable for ICU and HD	
Bathroom & follets Tor ICU and HD	
Hospital Routine Patient Facilities Personal Belongings	
Permission before leaving ward Day room. Responsibility for valuables	٠ ا
◆ To remain in hospital till discharge ◆ Telephone • Tolletries	
■ Visiting hours ■ Television ■ Televisi	
Hospital check-out time Air-conditioning	٠ ا
a. Trophea chocked and	
☐ Others (Please specify):	
	` `-
D. DETROUGH TETRO (Toward hours for the word for your days of the	\dashv
6 PERSONAL ITEMS (Personal Items kept in ward for use at own risk)	
Y No (If no, go to point 7)	` ['
⊒ Yes	
Vision aid Sa Glasses Wrist watch	 :
O Contact lens, specify	;
Continue to tal specify	
A Hardward C Creative	+
Hearing aid O Specify Handphone	
Denture O Specify MPPRY Lower (full Others	7
set)	. *
Walking device With patient	
Wheelchair	.
☐ Quad stick	
☐ Walking stick	
☐ Others (specify)	
SAFEKEEPING OF PERSONAL PROPERTIES	
No Identity Card or property received	[.
RECEIVED property for safekeeping, document in PROPERTY FORM	
CLARATION	
I have been orientated through the details above and understand the information provided by the attending nurse.	1
I understand that if I / the patient choose to keep any valuables or cash with me I him I her during hospitalisation,	-
I shall not hold CLEMENTI Hospital responsible in any way in the event of loss or damage to the valuables / cash.	1
Walter Only V	
tvice given to: HENG PAN YUI	4
Name Signature Relationship	
lvice given by: AMY CHUA EN	1
vice given by:	- · ·
Name Signature Designation	
Section A assessed by:	
A and EN EN AMY CHUA 3	ľ
Designation Name Signature Date Time	┨.
	1.
RN Marcy Tan . On 11:40	Ⅎ.
Designation Name Signature Data Time.	.]

;		TION A: Complete within 4 hours of admission by EN and above
*. * *		
		COGNITION / PERCEPTION PATTERN Level of consciousness: ☐ Alert ☐ Confused ☐ Drowsy ☐ Unresponsive ☐ Disorientated
.	/	Orientated to: Day D'Time. Person Place
. ?	Ы)	Sensory;
	Β,	. □ Paralysis . □ Tingling . □ Tremors
.	c)	tearing: Right 🖾 Normal 🗆 Impaired (specify) 🗀 Unable to assess
		Left Normal Impaired (specify) Unable to assess
	d)	/ision: Right Normal Impaired (specify) Unable to assess
	*	Left Normal Impaired (spediy) Unable to assess
	_;	
. 1	10	RESPIRATION
		Breathing pattern Presence of symptoms:
•		☑ Regular ☐ Irregular ☐ Nil ☑ Dyspnoea ☐ Cough ○ Productive ○ Haemoptysis ○ Non productive
٠.		Remarks Strylet 4013 Vlasponodian nate 28-30/m. 500-(PA) 94%.
1) 1)	11	CIRCULATION Presence of symptoms:
1	-	Charles Charles Charles Charles Charles Charles
		Regular I megular I nit I chest pain I chest ugnitiess I didulless I december I chest ugnitiess I didulless I december I chest ugnitiess I december I chest ugnities I december I chest ugnitie
		Extremities
٠.		□ Warm □ Cold □ Clammy □ Cyanosed
		Remarks
*	An'	PAIN / COMFORT
4	12.	Presence of Pain Mark a cross (X) or shade the affected areas
		□ No (If no, go to Item 13) □ No, pain resolved after treatment at A&E. Complete pain assessment
٠. ٠.		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? Epigadaic regime
	а.	Location of Pain: Where does it num?
! .	ί L Ρ	PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale
		Tick scale used VNP SPD FPR
•	C.	
(*)	d	Duration: How long have you had this pain? (how days / months / years)
		Verbal Numerical Pain (VNP) Scale
	ė	Quality; Is the pain constant, dull, sharp, burning or on and off?
	1	constant of dull
		Simple Pain Descriptive (SPD) Scale
	ŧ	Does your pain affect your usual daily routine? No pain O
		□ No □ Yes No pain 0 ○ Performs ADL with discomfort Mild pain 2
		ØInterferes with ADL and sleep Moderate pain 5
: .		Ogthers Severe pain 8
		Faces Pain Rafing (FPR) Scale
	٠.	
040	13	Section A assessed by:
	10000	EN AMY (HGA 11:31.
	EN	Designation Name Signature time
	SN	RN Maicy Tun m 11241.
	1 -	Designation Name Signature Bate Time

14	CTION B:Complete within 24 hor		f admission by RN	S23154 3lk 648	O YIN 1791 3, Clemen 3 S 6506	iti Ave 4, 348
	Questions	1	Response			Score.
 a	History of diabetes		No (go to item 15)			O ·
•		D	Yes			
h·	Newly diagnosed dlabetes	D	No			, o
٠.			Yes			4
_:	On oral diabetes medication or INSULIN	.0	No		•	0
	therapy		Yes, please specify: O Tablet			1
	шылру		O Insulin(with or without lable	ets)		4
<u>.</u>	Previous or current problem with FEET	Ø	No			0.
۵	Previous of current problem with the		General complaints (numbness, lingling sensation/pin	and nee	dles)	1 .
			Active ulcers / Previous amputation			4
			No		··· ;	· i
е	Patient is admitted for Hypoglycaemia	. 4			······································	4
_			Yes	· · · ·		
	IF TOTAL SCORE IS ≥ 4:	Z. N			i Score	0.
	Fax "Assessment of Diabetes" section to Dia					
b)	For ICU or HD patients, tax "Assessment of I	Diabete	s" section on day of transfer to general ward		•	
-					S.E.;	
	Remarks					
15	NUTRITIONAL SCREENING (Complete the sc	reenin	g by ticking as appropriate)			,
	Nutritional indicator		Status,		Yes	No
					·	
	Food Intake Decreased persis	tently o	ver the past 3 months due to loss of appetite,		Ø	'Bac
	Food intake Decreased persis digestive problem	tently o	ver the past 3 months due to loss of appetite, omitting, chewing or		A	100g/c
	Food Intake Decreased persis digestive problem	tently o s e.g. v	ver the past 3 months due to loss of appetite, omitting, chewing or	. :	.,	
	Food Intake Decreased persis digestive problem Mode of feeding Tube feed	tently o	ver the past 3 months due to loss of appetite, omitting, chewing or			14
	digestive problem Mode of feeding Tube feed	se.g. v	omitting, chewing ar			A
	digestive problem Mode of feeding Tube feed	se.g. v	ver the past 3 months due to loss of appetite, omitting, chewing or greater than 3kg (6.6lbs) during last 3 months		.,	
	Mode of feeding Tube feed Weight loss Unintentional weight	s e.g. v	omitting, chewing or greater than 3kg (6.6libs) during last 3 months	.:		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	Mode of feeding Tube feed Weight loss Unintentional weighter-related condition Wounds / pressure	s e.g. v	omitting, chewing or greater than 3kg (6.6lbs) during last 3 months	:		A
	Mode of feeding Tube feed Weight loss Unintentional weight loss Wounds / pressur Wounds / pressur Multiple trauma on	s e.g. v oht loss e sores multipl	omitting, chewing or greater than 3kg (6.6lbs) during last 3 months			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	Mode of feeding Tube feed Weight loss Unintentional weight related condition Wounds / pressur Multiple trauma or Signs of muscle weights	s e.g. v pht loss e sores multipl	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla			Q Q
	Mode of feeding Tube feed Weight loss Unintentional weight related condition Wounds / pressur Multiple trauma or Signs of muscle we Pre / post major s	s e.g. v pht loss e sores multipl	omitting, chewing or greater than 3kg (6.6lbs) during last 3 months			A O Y O
	Mode of feeding Tube feed Weight loss Unintentional weight related condition Wounds / pressur Multiple trauma or Signs of muscle weights	s e.g. v pht loss e sores multipl	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla			A CO A
	Mode of feeding Tube feed Weight loss Unintentional weight related condition Wounds / pressur Multiple trauma or Signs of muscle we Pre / post major s	s e.g. v pht loss e sores multipl	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla			
	Mode of feeding Tube feed Weight loss Unintentional weighter-related condition Mounds / pressur Multiple trauma or Signs of muscle weighter post major s Sepsis / infection	s e.g. v pht loss e sores multipl vasting	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla			A CO A
	Mode of feeding Tube feed Weight loss Unintentional weight related condition Wounds / pressur Multiple trauma or Signs of muscle we Pre / post major s Sepsls / infection Cancer Gastrointestinal d	ght loss e sores e sores urgery	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla			
	Mode of feeding Tube feed Weight loss Unintentional weight related condition Wounds / pressur Multiple trauma or Signs of muscle we Pre / post major s Sepsls / infection Cancer Gastrointestinal d	ght loss e sores e sores urgery	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla eg. Abdominal, ENT surgery and others			0位在在0位在 0位在
	Mode of feeding Tube feed Weight loss Unintentional weight loss Wounds / pressur Multiple trauma or Signs of muscle w Pre / post major s Sepsis / infection Cancer Gastrointestinal d Therapeutic diet a	ght loss e sores e sores urgery	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla eg. Abdominal, ENT surgery and others			0位在在0位在 0位在
	Mode of feeding Tube feed Weight loss Unintentional weight related condition Wounds / pressur Multiple trauma or Signs of muscle we Pre / post major s Sepsis / infection Cancer Gastrointestinal d Therapeutic diet e	ght loss e sores e sores urgery	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla eg. Abdominal, ENT surgery and others low salt, low cholesterol If:			0位在在0位在 0位在
	Mode of feeding Tube feed Weight loss Unintentional weight loss Wounds / pressur Multiple trauma or Signs of muscle w Pre / post major s Sepsis / infection Cancer Gastrointestinal d Therapeutic diet a	ght loss e sores e sores urgery	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla eg. Abdominal, ENT surgery and others low salt, low cholesterol If: □ on tube feed Refer dietitian on			0位在在0位在 0位在
	Mode of feeding Tube feed Weight loss Unintentional weight loss Wounds / pressur Multiple trauma or Signs of muscle w Pre / post major s Sepsis / infection Cancer Gastrointestinal d Therapeutic diet a	ght loss e sores e sores urgery	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla eg. Abdominal, ENT surgery and others low salt, low cholesterol If:			0位在在0位在 0位在
	Mode of feeding Tube feed Weight loss Unintentional weight loss Wounds / pressur Multiple trauma or Signs of muscle w Pre / post major s Sepsis / infection Cancer Gastrointestinal d Therapeutic diet a	ght loss e sores e sores urgery	greater than 3kg (6.6lbs) during last 3 months le fractures / cachexla eg. Abdominal, ENT surgery and others low salt, low cholesterol If: □ on tube feed Refer dietitian on			0位在在0位在 0位在

Remarks	OEL	
Contented to: Chart Chartest Chartes		THE WINDS OF THE PROPERTY OF T
Color totaled to: G Day GTITINE Fersion Phace Color Colo		
Distriction	a)	Level of consciousness.
Hearting: Right Journal Impaired (epacity) Unitable to assess	į	Orientated to: Day Time Li Person La Place
Description Paralysis Tringling Tremone Paralysis Tringling Tremone Paralysis Unable to assess Laft Normal Impaired (specify) Unable to assess Laft Normal Impaired (specify) Unable to assess Presence of Expression Unable to assess Presence of Expression Unable to assess Present Presence of Expression Unable to assess Present Presence of Expression Productive Non-productive		□ Auto
c) Hearting: Right: Normal Impalited (specify) Untable to assess:	b)	Sensory:
Comparing Comp		
Vision: Right Normal Impaired (epectry) Unable to assess	c)	Hearing: Night 42 30th at
Impaired (apedity)	,	Left Normal Impaired (specify) Li Unable lo assass
Impaired (epectry) Unable to assess	٦١.	Vision Richt ☑ Normal ☐ Impaired (specify) ☐ Unable to assess
Regular Irregular Presence of symptoms: Cough Productive Haemophysis	",	
10 RESPIRATION Breathing pattern Regular		
Breathing pattern Regular Inregular Nil Dysphosa Cough Productive Haemoptysis		Remarks
Regular Irregular Nil Dysphosa Cough Productive Haemoptysis Romarks Maff. 40 Magnitudin Ade 28 - Magnitudin 94 90 Remarks Maff. 40 Magnitudin Ade 28 - Magnitudin 94 90 It CIRCULATION Presence of symptoms: Chest tightness Gliddness Dedema Extremities Warm Cold Clammy Cyanosad Remarks Mark a cross (A) or shade the affected areas on the body diagram below: No. (If no. for to from 13) Non-communicative patients at AAE. Complete pain assessment Non-communicative patients Pain Assessment Non-communicative patients Pain Assessment Protocol in Non-verbal / Non-communicative patients Pain Assessment Location of Pain: Where does it hurt? Magniture Pain Assessment Dean Severity Score: How bad is the pain? Use only ONE pain scale T Regular Regular Dean Severity Regular	10	
Regular Iregular Nil		
Remarks Cold Cold	ĺ	· · · · · · · · · · · · · · · · · · ·
11 CIRCULATION Pulse Presence of symptoms: Chest tightness Gliddness Gedena	100	· · · · · · · · · · · · · · · · · · ·
11 CIRCULATION Pulse Presence of symptoms: Chest tightness Gliddness Gedema		1284 LOR Vaccintin rate 28- 20/m. Sporton 8492.
Pulses	1	Remarks 711g/m 1770
Pulse	11	CIRCUI ATION
Regular		Parameter of property and the second of the
Extremities Warm Cold Clammy Cyenosed	\sim	ruise
Remarks Cold		Regular JZ stegular Z start Z
Remarks 12 PAIN I COMFORT Presence of Pain No (If no, go to item 13) On the body diagram below: No, pain resolved after treatment at A&E. Complete pain assessment Ves. Complete pain assessment One-communicative patients Non-communicative patients Pain Assessment One-communicative patients Pain Assessment Location of Pain: Where does it hur? Image: Pain Assessment Pain Assessment Duration : How long have you had this pain? (hotel) / days / months / years) Aby One-tail Others Ouse your pain affect your usual daily routine? One-tail Others One-tail Others Score No pain Others Section A assessed by: EN		
PAIN / COMPORT Presence of Pain		. □Warm □Cold □ Clarmy □ Cyanosad
PAIN / COMPORT Presence of Pain	1	
Presence of Pain	1	Remarks
Presence of Pain No (If no, go to Item 13)	15	DAIN / COMPORT
No (If no, go to Item 13)	12.	
No, pain resolved after treatment at A&E. Complete pain assessment Yes. Complete pain assessment Yes. Complete pain assessment Non-communicative patients Non-communicative patients Non-communicative patients Pain Assessment Location of Paint: Where does it hurt? Pain Assessment Location of Paint: Where does it hurt? Pain Assessment Location of Paint: Where does it hurt? Pain Assessment Recommunicative patients Recommunicative pa		
Yes. Complete pain assessment Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal / Non-communicative Patients" Pain Assessment Pain Assessment Pain Assessment Location of Pain: Where does it hur? Spigalic Nog.	· .	E No (n no) go to to to to
Non-communicative patients Palin Assessment Protocol in Non-verbal		
Non-communicative Patients Pain Assessment a Location of Paint: Where does it hur? PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale: 7 R. L. L. L. R. C Tick scale-used VNP SPD FPR d Duration: How long have you had this pain? (how / days / months / years) Verbal Numerical Pain (VNP) Scale C Quality: Is the pain constant, dull, sharp, burning or on and off? Constant of dutt Simple Pain Descriptive (SPD) Scale Score No pain 0 Mild pain 2 Moderate pain 5 Severe pain 8 Facas Pain Rating (FPR) Scale O Others 13 Section A assessed by: EN EN Amy (Hua Sirents III)	-1	CYes. Complete pain assessment
Pain Assessment a Location of Pain: Where does it hurt? Lipidate and Location of Pain: Where does it hurt? Lipidate and Location of Pain: Where does it hurt? Lipidate and Location of Pain: Where does it hurt? Location are constant and this pain? Use only ONE pain scale: 7 R. L. L. L. L. L. R. L. L. L. R. L. L. L. R. L. L. R. L. L. L. L. L. R. L. L. L. L. R. L. L. L. L. R. L.		☐ Non-communicative patient, refer to "Pain Assessment Protocol in Non-verbal /
a Location of Pain: Where does it hur? b PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale: 7. R. L. L. L. R. c Tick scale used VNP SPD FPR d Duration: How long have you had this pain? (how of days / months / years) Verbal Numerical Pain (VNP) Scale 6 Quality: Is the pain constant, dull, sharp, burning or on and off? Conctant of dull Simple Pain Descriptive (SPD) Scale Score No pain 0 Mild pain 2 Moderate pain 5 Severe pain 5 Severe pain 5 Severe pain 8 Faces Pain Rating (FPR) Scale 13 Section A assessed by: EN EN AMY (H4A		Non-communicative Patients*
a Location of Paint: Where does it hurt? b PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale: 7. R. L. L. L. R. c. Tick scale used VNP		
b PAIN SEVERITY SCORE: How bad is the pain? Use only ONE pain scale: 7 R L L L L C Tick scale-used VNP SPD FPR d Duration: How long have you had this pain? (how I days / months / years) Verbal Numerical Pain (VNP) Scale Simple Pain Descriptive (SPD) Scale Score No pain 0 No pain 0 Mild pain 2 No performs ADL with discomfort Interferes with ADL and sleep Others Severe pain 8 Faces Pain Rating (FPR) Scale 13 Section A assessed by: EN FN AMY (HAA Simple)		Pein Assessment
c. Tick scale used VNP SPD FPR d Duration : How long have you had this pain? (hotins) / days / months / years) e. Quality : Is the pain constant, dull, sharp, burning or on and off? Conctruit of ductors Simple Pain Descriptive (SPD) Scale	. а	Location of Pain: Where does it hun?
c. Tick scale used VNP SPD FPR d Duration : How long have you had this pain? (hotins) / days / months / years) Verbal Numerical Pain (VNP) Scale e Quality : Is the pain constant, dull, sharp, burning or on and off? Conctruit of ductors Simple Pain Descriptive (SPD) Scale Score No pain	1 :	Now and property accounts. How had to the pain? Use only ONE pain scale: 7
d Duration: How long have you had this pain? (how fire / days / months / years) Verbal Numerical Pain (VNP) Scale Verbal Numerical Pain (VNP) Scale Simple Pain Descriptive (SPD) Scale Simple Pain Descriptive (SPD) Scale Score No pain O Mild pain O Mild pain O Mild pain Severe pain	р	PAIN SEVERITY SCORE: FOW dad is the paint of the state of
d Duration: How long have you had this pain? (hoting / days / months / years) Verbal Numerical Pain (VNP) Scale Verbal Numerical Pain (VNP) Scale Simple Pain Descriptive (SPD) Scale Simple Pain Descriptive (SPD) Scale Score No pain O Hild pain O Mild pain Severe pain	1.	Tek emile used F/VNP : □ SPD □ EPR
Verbal Numerical Pain (VNP) Scale a Quality: Is the pain constant, dull, sharp, burning or on and off? Conctant a dull Simple Pain Descriptive (SPD) Scale Score No pain O Performs ADL with discomfort Interferes with ADL and sleep O Others 13 Section A assessed by: EN EN AMY (HGA	, ,	
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Simple Pain Descriptive (SPD) Scale Does your pain affect your usual daily routine? Score No pain D		
f Does your pain affect your usual daily routine? No Yes O Performs ADL with discomfort Interferes with ADL and sleep Others Severe pain 8 Faces Pain Rating (FPR) Scale Faces Pain Rating (FPR) Scale	ė	Quality: Is the pain constant, dull, sharp, burning or on and off?
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No pain 0 No pain 0 Mild pain 2 Moderate pain 5 Severe pain 8 Faces Pain Rating (FPR) Scale 13 Section A assessed by: EN EN AMY (HGA		Simple Pain Descriptive (SPD) Scale
No Performs ADL with discomfort O Performs ADL with discomfort Officeries with ADL and sleep O Others 13 Section A assessed by: EN EN AMY (HLA		Does your pain affect your usual daily routine?
O Performs ADL with discomfort Interferes with ADL and sleep O Others O Others Faces Pain Rating (FPR) Scale	1.	l No pain · l · D
Interferes with ADL and sleep Others Moderate pain Severe pain Severe pain Faces Pain Rating (FPR) Scale		
Severe pain 8 Faces Pain Rating (FPR) Scale Severe pain 8 Faces Pain Rating (FPR) Scale Severe pain 8 Faces Pain Rating (FPR) Scale		
Faces Pain Rating (FPR) Scale Section A assessed by: EN EN Street, CHUA STREET, CHU		
13 Section A assessed by: EN EN Signature Signature Signature Signature Time T		Outlets
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13 Section A assessed by: EN EN AMY (HGA Simples Time		
EN EN AMY CHUA Simetro Tim	8	MO HUNT PLUES HUNTS HUNTED HOUSE LINE WORKER
EN EN AMY CHUA Simply Tim	49	Section A assessed by:
	, ,,	5- INDIC
Designation	8	1-1 And Y (HIA)
SN RN Marcy Tan on 111 1124		Designation Name Signature 7 Time

17 ORAL CAVITY	and the sign of the found that the same a self of	
Mouth / Tongue:	☐ Moist , ☑ Dry , ☐ Coated ☐ Ulicer	·
Teeth:	☐ Intact ☐ Loose (specify)	
redu.	Dentures : Q Upper Q Lower	1.
	□ Na □ Nausea □ Vomitting □ Difficulty in	n entallowing
Presence of:	□ Nii 9 Nausea □ Vomitting □ Difficulty ii	i structing
Remarks		- ` `
18 SKIN		
. Colour:	integrity ☐ Flushed ☐ Jaundiced ☐ Impaired	
a management of	Description Situation	(Specify)
: · V	CI Plinter	;
	☐ Others (Specify): ☐ Superficial broken skin	٠.,
, , , , , , , , , , , , , , , , , , ,	T Bruises	
Body Temperature	re ☐ Rashes	
Normal Normal by	body temperature . Redness	
Raised body		
Nalsed body	1	
Remarks		
**************************************	SK ASSESSMENT: BRADEN SCALE	
		Score
Braden scale criteria		
Sensory perception	1. Completely limited 2. Very limited 3. Slightly limited 4. No impairment	3.
Moisture	Constantly moist	3:
Activity	1. Bed bound 2. Chair bound 3. Walk Occasionally 4. Walk frequently	3.
Mobility	1. Immobile 2. Very limited 3. Slightly limited 4. No limitation	3
Nutrition	1. Very poor 2. Probably adequate 3. Adequate 34. Excellent	不适
Friction and sheer	1. Problem 2. Potential problem 3. No apparent problem	3 : Am
		11 100 30
	Total score	16 166-
		16 16 El
JF SCORE IS ≤16 —	▶ ☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for	
JF SCORE IS ≤16 —▶		
JF SCORE IS ≤16 —▶	▶ ☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for	
	▶ ☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for	
JF SCORE IS ≤16 — P	▶ ☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for	lb € € E Chulu
	▶ ☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for	
Remarks	▶ ☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for	
Remarks 19 ELIMINATION a Urinary Appearance:	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of:	Chu
Remarks 19 ELIMINATION a Urinary Appearance:	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: □ Cloudy □ Haematuria □ Dribbling □ Frequency □ In	Chui
Remarks 19 ELIMINATION a Urinary Appearance:	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: ☐ Cloudy ☐ Haematuria ☐ Dribbling ☐ Frequency ☐ Intervence ☐ Urgency ☐ Burning sensation ☐ Frequency ☐ Reduced ☐ Urgency ☐ Burning sensation ☐ Frequency ☐ Reduced ☐ Urgency ☐ Burning sensation ☐ Frequency ☐ Reduced ☐ Urgency ☐ Burning sensation ☐ Frequency	Chu
Remarks 19 ELIMINATION a Urinary Appearance: Clear	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: □ Cloudy □ Haematuria □ Dribbling □ Frequency □ Initiation Initiati	Chui
Remarks 19 ELIMINATION a Urinary Appearance: Clear Adaptive aids:	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: ☐ Cloudy ☐ Haematuria ☐ Dribbling ☐ Frequency ☐ Intervence ☐ Urgency ☐ Burning sensation ☐ Frequency ☐ Frequency ☐ Frequency ☐ Frequency ☐ Frequence ☐ Urgency ☐ Burning sensation ☐ Frequence ☐ Others (specify)	Chui
Remarks 19 ELIMINATION a Urinary Appearance: Clear Adaptive aids:	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: ☐ Cloudy ☐ Haematuria ☐ Dribbling ☐ Frequency ☐ Intervence ☐ Urgency ☐ Burning sensation ☐ Electron ☐ Chers (specify)	Chui
Remarks 19 ELIMINATION a Urinary Appearance: Clear Adaptive aids:	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: ☐ Cloudy ☐ Haematuria ☐ Dribbling ☐ Frequency ☐ Intervence ☐ Urgency ☐ Burning sensation ☐ Frequency ☐ Frequency ☐ Frequency ☐ Frequency ☐ Frequence ☐ Urgency ☐ Burning sensation ☐ Frequence ☐ Others (specify)	Chui
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Remarks 19 ELIMINATION a Urinary Appearance: Clear Adaptive aids: Nil	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: ☐ Cloudy ☐ Haematuria ☐ Dribbling ☐ Frequency ☐ Industrial ☐ Urgency ☐ Burning sensation ☐ Frequency ☐ Industrial ☐ Others (specify) ☐ Diapers ☐ Industrial ☐ Others (specify): ☐ Diapers ☐ Industrial ☐ Others (specify):	Chui
Remarks 19 ELIMINATION a Urinary Appearance: Clear Adaptive aids: Nil Remarks b Bowel	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: ☐ Cloudy ☐ Haematuria ☐ Dribbling ☐ Frequency ☐ Interpreted ☐ Urgency ☐ Burning sensation ☐ Chaers (specify) ☐ Diapers ☐ Indwelling catheter ☐ Urosheath ☐ Others (specify): am (specify) ☐ 1 × 2ex 2-3 days	Chui
Remarks 19 ELIMINATION a Urinary Appearance: Clear Adaptive aids: Nil Remarks b Bowel Usual bowel patter	☐ Initiate pressure ulcer risk intervention and document in Risk Assessment Protocol for Pressure Ulcer and Inpatient Clinical Notes (Nursing Notes and Plan of Care) Presence of: ☐ Cloudy ☐ Haematuria ☐ Dribbling ☐ Frequency ☐ Industrial ☐ Urgency ☐ Burning sensation ☐ Frequency ☐ Industrial ☐ Others (specify) ☐ Diapers ☐ Industrial ☐ Others (specify): ☐ Diapers ☐ Industrial ☐ Others (specify):	Chui

	FUNCTIONAL STATUS				f	Ĭ
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_	New onset difficulty with the following;	No .	Yes	If yes, automatic referral (except for ICU & HD case frauma and RTA cases)	s, spinal injuries,	
	Ambulation	./		Physiotherapist on		1.
	Tolleting / Bathing					
	Dressing / Grooming	/	,			
	Transfer	/		Occupational Therapist on		
	Feeding				· .	
	Speaking					1.
	Swallowing	· V.		Speech Therapist on		
l	Swanowing	!				
				* . * .	, w - 6	1.
	Remarks					1
	ASSESS IN GENERAL WARD : Di	te Assessed				
4	FALL RISK ASSESSMENT	☐ (For Unconscious	patient, proceed to Item	No. 22 Sleep Pattern)		1
			<u> </u>	· · · · · · · · · · · · · · · · · · ·	<u> </u>	- -
m	Mor	se Scale Criteria			Score (circle the number)	
1	History of fall (Include current admis	sion and last 12 months)			(No) - 0	7.
					Yes 25	
2	Has a secondary diagnosis e.g with	comorbidities, polypharma	acy :	• • • • • • • • • • • • • • • • • • • •	No 0	+
	(If more than 1 medical diagnosis		•	* **	(Yes) 15	١.
3	Receive: IV thereby./ hep.				No 0	┤.
				7	Yes 20 .	<u></u>
4		e / bedrest / nurse assist		, .,	(0)	Ⅎ.
	● Crù	ches / stick / umbrella / qu	adstick / frame	· ·	15	
	• Hole	ls on to furniture	·	<u> </u>	. 30	_
5, .	Galt is: • Nor	mal / bedrest / Wheelchair				
•	. · We	ik .	<u> </u>		70	
	a Imp	aired :		969	20] ·
6.	Mental Status • Oris	entated to own ability			. (6)	
	• · · • Ove	restimated / forgets limitat	ions .	•	15	
-50 -50		,	•	Total Scor	35	
sc	ORE IS ≥ 45	t fall precautions and docu	ment in Risk Assessment	for Falls and		7
,	Inpatient	Clinical Notes (Nursing No	tes and Plan of Care).		æ1	
	3 a 5 a 6	*1		•		
	Remarks	•				
2	SLEEP PATTERN	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·		··· · · · · · · · · · · · · · · · · ·	-
-2		. 🛘 Yes 🐧	Interrupted O Ins	omnia O Others, specif	V	
	Sleep Problem ☐ No					
		5 (5)	• •			
	Remarks					
						_

23	PSYCHOLOGICAL REACTION
	No apparent problem . Problem .
	/ Transfel Mithdemen Dettable 1880
	☐ Aggressive ☐ Violent ☐ Angry
	Expressed
٠	☐ Guillt ☐ Shame ☐ Negative feeling about self ☐ Feeling tired at all times
	Difficulty in concentrating, remembering things or decision making
10	
	☐ Others (specify)
6	If ≥ 1 tick, inform doctor and document in Inpatient Clinical Notes (Nursing Notes and Plan
55 1.30	of Care)
10.00	
	Remarks
24	SPIRITUAL / CULTURAL
	Religion
**	Buddhism
	— · · · · · · · · · · · · · · · · · · ·
9.	□ Free thinker □ Islam □ Christianity □ Others
	Any concern related to diet Any other concern
-	Any concentration of Yes, specify Your Atherite , No Yes, specify
	□ No □ Yes, specify Your Affect te □ No □ Yes, specify
v	Remarks rapid weight loss 11/69 7 3 month's time.
25	ECONOMIC & FINANCIAL SUPPORT
	- Devents Children
٠.	Employer Communication Communi
	☐ Public Assistance ☐ Relatives ☐ Friends ☐ Others
. 1	
	Remarks
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26	SOCIAL HISTORY
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а	SOCIAL HISTORY Accommodation: With family, specify Live alone Others (specify)
a b	SOCIAL HISTORY Accommodation:
a b c d	SOCIAL HISTORY Accommodation:
а b c d	SOCIAL HISTORY Accommodation:
a b c d	SOCIAL HISTORY Accommodation:
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27 (i)	Accommodation: With family, specify Live alone Others (specify) Type of housing: Private Condominium HDB Others Toilet: (If applicable) Sitting Squatting Lift landing at: (If applicable) Same level Different level Remarks IDENTIFIED DISCHARGE PLANNING CONCERN (If applicable) Is patient caring for him/her self Yes No (a) Does the patient has a primary caregiver? No Yes, specify No Yes hours Any discharge planning concerns? No Yes Pinancial No carer Clinical (Nursing home) Specify Specify No Carer Clinical (Nursing home) Specify Carer Carer Clinical (Nursing home) Specify Carer Carer Carer Clinical (Nursing home) Carer Carer Carer Carer Carer Carer Clinical (Nursing home) Carer Carer
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23	PSYCHOLOGICAL REACTION
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	/ Transfel Mithdemen Dettable 1880
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	Expressed
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55 1.30	of Care)
10.00	
	Remarks
24	SPIRITUAL / CULTURAL
	Religion
**	Buddhism
	— · · · · · · · · · · · · · · · · · · ·
9.	□ Free thinker □ Islam □ Christianity □ Others
	Any concern related to diet Any other concern
-	Any concentration of Yes, specify Your Atherite , No Yes, specify
	□ No □ Yes, specify Your Affect te □ No □ Yes, specify
v	Remarks rapid weight loss 11/69 7 3 month's time.
25	ECONOMIC & FINANCIAL SUPPORT
	- Devents Children
٠.	Employer Communication Communi
	☐ Public Assistance ☐ Relatives ☐ Friends ☐ Others
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	Remarks
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		HARGE CHES To be completed on day					2
Date of discharge	: Time .					1	
Nursing Home Specify	☐ Community Hospital	☐ AMKH ☐ Others. ☐ Stretch		sion □ S.	ACH 🗆 s	St.Lukes	
		Checked and return					1 1 .
Removal of : IV cannula Drain(s) Catheter Identification band		Private X-ra	ations specify		(na. c	of films) .	
☐ Others		☐ Others, spec	cify	:;-	-::		,
	y 200			75-7000000000		~	
1 Rt. Lang M. 41-10 467-4	mhor						· · · ·
Discharge Medical Certificate Nu Discharge Memorandum (2 copie			· · · · · · · · · · · · · · · · · · ·			20 00	
STO date: Types of dressing and date due: Follow-up appointment (Doctors)		Others }					•
TCU	Name	Designation	Date .	Ţime	Memo	given	1
				٠. ٠	☐ Yes	□ No	
		· · · · · · · · · · · · · · · · · · ·		·	☐ Yes	□ No	l
<u> </u>		 		· · · · ·	☐ Yes	□ No	· .
		· · · · · · · · · · · · · · · · · · ·		· · ·	□ Yes	□ No	1
		: : :			☐ Yes	□ No	1
☐ Special Instructions:							_ :
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			. /				
☐ Referrals: OPS/ HNF / Hospice / O							- 1
☐ Medications given / counselled by		clst O Nurse		ng n			
	nlicable			i Dain M	anagement		
☐ Medik Awas application form if app		Lall procedition					٠.
☐ Medik Awas application form if app Advice on: ☐ Wound care	☐ Head injury advice	☐ Fall precaution	advice	·	·		
☐ Medik Awas application form if app	☐ Head injury advice	☐ Fall precaution	advice			<u></u>	<u> </u>
☐ Medik Awas application form if app Advice on: ☐ Wound care ☐ Other discharge teaching / instructi	☐ Head injury advice ions, specify	***************************************	advice	La Paul W		<u>:: Å.:</u> :	<u> </u>
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