REGINA MEDICAL CENTER

Organization: _____ **Caller:** _____ **Telephone:** _____

Call date: _____ **Call time:** _____ am / pm **Signature of staff taking call:** _____

PATIENT INFORMATION:

Patient Name: _____ SS#: _____
Age: _____ DOB: _____ Sex: ___ Male ___ Female
Home Phone: _____ Alternate Phone: _____
Address: _____
Primary Physician: _____ Contacted: ___yes ___no
Other Physicians: _____
Psychiatrist: _____
Family Member / Guardian / Conservator: _____
Legal Status: _____ Phone: _____
Comments: _____

INSURANCE:

PERMISSION TO VERIFY BENEFITS? ____ Yes ____ No
Primary: _____ Phone: _____
Secondary: _____ Phone: _____
Medicare: ___A ___B Medicare #: _____
Medicaid #: _____

PRE-ADMISSION ASSESSMENT:

Medical status: _____
Presenting Problem / History of MH / CD treatment: _____
_____
_____
Goals of care: _____
Medical Conditions: _____
_____
_____
Vision: _____ Hearing: _____
ADLs: ___Independent ___Assisted ___Continent ___Incontinent ___Hx Falls
___Ambulatory ___With Assist ___Cane ___Walker Diet: _____

DISPOSITION AND STATUS:

___ Assessment Scheduled ___ Admission Criteria Not Met ___Refused Admission or Assessment
___ Referred for Medical Clearance ___ Not PPO/HMO ___ Referrals given: _____
___ Age Inappropriate ___ Pre-Certification Denied ___Admitted:___Voluntary___Involuntary
___ Medical Condition Primary ___ Other (Describe): _____

Physician Contacted for Admission Disposition: _____ Date/Time: _____

Disposition per Physician: _____ Date/Time: _____

Clinician Signature: _____ Date/Time: _____

Patient Label

SCREENING ASSESSMENT
GRACE Unit

REGINA MEDICAL CENTER

Information to gather for Physician:

S: Living situation: _____
_____
_____

Reason for admission: _____
_____
_____

B: Hospitalizations or illnesses the last 6 months: _____
_____

Falls: _____

CT: _____

Labs: _____

Height: _____

Weight:_____

Medications:

PRN meds _____

Narcotics / benzodiazepines _____

start / change _____ date: _____

Antipsychotics / antidepressants _____

start / change _____ date: _____

Influenza vaccine ___ yes ___no date given: _____

Pneumonia vaccine ___ yes ___no date given: _____

A: Most recent vital signs: _____

Wounds: _____

Bowel status: _____

Respiratory status: _____

UTI: _____

Pain: _____

Mental status change: _____

Code status: _____

RN Signature: _____ **Date:** _____

Patient Label

SCREENING ASSESSMENT
GRACE Unit