

OUTPATIENT QUESTIONNAIRE/ASSESSMENT RADIOLOGY & MEDICAL IMAGING DEPARTMENT

Patient Information and History

Name: _____ Date of Birth: _____ Today's Date: _____

Ordering Physician: _____

Exam(s) being done today: _____

Briefly explain to the best of your knowledge the reason for this exam: _____

What is the primary language spoken? _____

1. Do you need assistance walking and/or standing? Yes No

2. Are you "at risk" of falling? Yes No

3. Have you had any recent falls? Yes No

Date of recent fall: _____ Briefly explain: _____

4. Is there anyone with you today? Yes No

5. Do you have any known allergies to latex products? Yes No

6. Are you allergic to any medications? Yes No

If yes, what type(s)?: _____

7. Are you diabetic? Yes No

X-Ray, CT and Ultrasound patients:

8. Have you had any chemotherapy? Yes No

9. Have you had any radiation therapy? Yes No

10. Have you had any type of cancer? Yes No

Type of cancer: _____ Date Diagnosed: _____

11. Please list all surgical procedures: _____

12. Have you had any previous imaging studies? Yes No *If yes, please indicate below:

<u>Type of Study</u>	<u>Date</u>	<u>Facility</u>
Radiograph (X-Rays)	_____	_____
Computed Tomography (CT Scan)	_____	_____
Nuclear Medicine (Bone Scan)	_____	_____
MRI (Magnetic Resonance Imaging)	_____	_____
Ultrasound (Sonogram)	_____	_____
Other	_____	_____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS



51221 (Rev. 06/09)

**OUTPATIENT QUESTIONNAIRE
& ASSESSMENT**

RAD-024

**OUTPATIENT QUESTIONNAIRE/ASSESSMENT
RADIOLOGY & MEDICAL IMAGING DEPARTMENT**

Individualized Patient Care

1. What is one thing I can do for you to make sure you receive **very good** care today?

2. Are there any **special needs/considerations** that we should know about?

Medication List

Please list all medications you are currently taking:

Date	Medication Name	Dose	Frequency

Patient / Patient Caregiver Signature

Date

Clinician Signature (i.e. Medical Assistant)

Date

Clinical Signature (i.e. Technologist)

Date

**BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS**



51221 (Rev. 06/09)

**OUTPATIENT QUESTIONNAIRE
& ASSESSMENT**

**BAYLOR HEALTH CARE SYSTEM
PATIENT HISTORY FOR CONTRAST MEDIA**

Patient Name: _____ Date of birth: _____ Height: _____ Weight: _____

In order to assess your risk of complications and reduce risk for a contrast media allergic reaction please complete sections 1-3 below:

1. Please indicate if you have one of the following *:

- History of "kidney disease" as an adult or family history of kidney problems
- History of kidney transplant
- History of liver disease
- Diabetes
- Paraproteinemia syndromes or diseases (e.g. myeloma)
- Collagen vascular disease (e.g. Lupus)
- Recent contrast study (e.g. within the last 7 days)
- Recent surgeries? If yes, please list: _____
- Sickle cell disease

Certain medications:

- Metformin or metformin-containing drug combinations (Metformin, Avandamet, Glucophage, Glucophage XR, Actoplus Met)
- Regular use of nephrotoxic antibiotics, such as aminoglycosides, or non-steroidal anti-inflammatory drugs (e.g. Motrin, Aleve)

*** If you checked any of the boxes above, please inform your technologist now. You may require special instructions and further blood test(s) to assess your kidney function prior to receiving intravenous (IV) contrast media.**

2. Have you ever had an allergic reaction to intravenous contrast (e.g. iodine, gadolinium)? YES NO

If "YES", please describe*: _____

***If "YES", based on your reply, you may require pre-medication prior to receiving IV contrast, no IV contrast, or alternative imaging.**

3. Do you have a history of the following medical conditions:

- Asthma (if you have active asthma, bronchospasm, or bronchitis requiring treatment, please inform your technologist **now**)
- Cardiac Disease (angina, congestive heart failure, aortic stenosis, hypertension, primary pulmonary hypertension, severe but well compensated cardiomyopathy)
- History of allergic (anaphylactic) reaction to one or more allergens

Signed: _____ Date: _____ Time: _____
(Patient, Parent or Guardian)

To be filled out by the technologist performing your exam

_____ Exam Performed Per Protocol _____ Exam Performed Per Physician / Name: _____

Contrast IV - Type/Amount/Rate/Site: _____ Contrast Oral - Type/Amount: _____

Creatinine: _____ Result Date: _____ Estimated Glomerular Filtration Rate: _____

Technologist: _____ Date: _____ Time: _____

BAYLOR HEALTH CARE SYSTEM



BHCS-49045 (Rev. 02/10)

PATIENT HISTORY FOR CONTRAST MEDIA



Letter of Welcome

Dear Patient:

Our goal is to provide very good care in every aspect of your hospital visit. Our staff is committed to working together as a team to coordinate your care, manage your pain, and provide as much information as you want about your care.

We need your help. To improve your recovery and healing, please give us feedback on anything we can do to make you more comfortable during your stay.

While you are at Baylor, please feel free to call on your caregivers for any needs. If your caregivers are unable to answer your questions, please feel free to contact our Nursing Supervisor at 214-820-3013. If the Nursing Supervisor is unable to meet your needs, then do not hesitate to contact me at 214-820-4141. After hours, I may be reached at 214-549-4652.

Baylor strives to be the best place to give and receive safe, quality, compassionate healthcare. Thank you for allowing Baylor the opportunity to serve you.

Sincerely,

A handwritten signature in black ink that reads "John B. McWhorter". The signature is written in a cursive style.

**John B. McWhorter, III
President**

Baylor University Medical Center Pre-Admission

Pre-admission is located on the 2nd floor of Wadley Tower, Suite 254. Pre-admission is the process to complete all the paperwork and testing prior to the day of surgery. The test results (Labs, EKG, and Chest XRAY) will be sent to your physician's office for review. **If you have had recent tests elsewhere, please either bring those results with you or send them to your physician, as it may not be necessary to repeat them if they are current.** Please bring your driver's license or some other federally issued photo I.D. as this is the name we will use for your records. In addition, please bring a list of your current medications and any supplements you take.

Office Hours for Pre-admission are:

Monday – Friday 8 a.m. – 5 p.m.

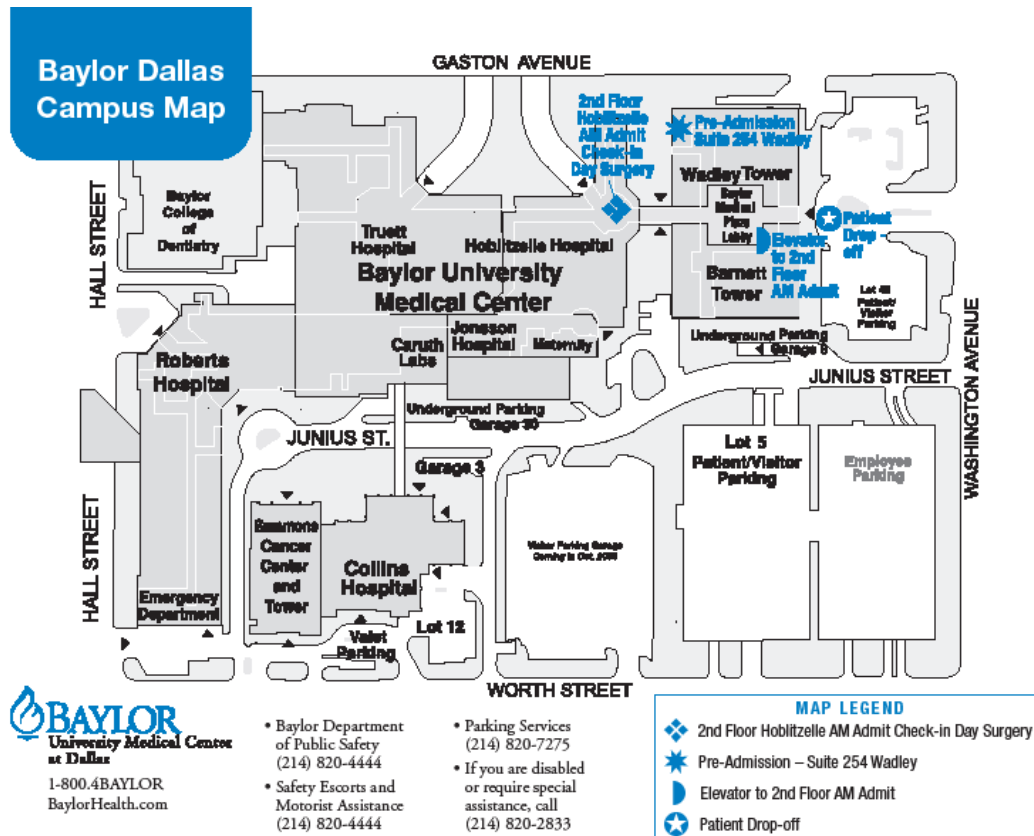
Pre-admission is closed weekends and holidays

Please call for all appointment to pre-admit at least 3 days prior to your scheduled surgery date.

Appointments can either be in person or by telephone. If you prefer a telephone appointment, we will need a good phone number to reach you and your preferred time of day to be called.

To schedule an appointment or if you have questions, please call:

214-820-6200 or 214-820-2078



Wadley 254 Pre Admit PATIENT PROFILE

PLEASE PRINT ALL INFORMATION

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____

Address: _____ Apt. No. _____ City: _____

State: _____ Zip: _____ Drivers License #: _____

Home Phone: () _____ Cell Phone: () _____ DOB ____/____/____
(Please indicate preferred number with an asterisk *)

Soc Sec # ____ - ____ - ____ Gender: M ___ F ___ Ethnicity: White ___ Black ___ Hispanic ___ Other _____

Marital Status: M ___ D ___ W ___ S ___ Separated ___ Other _____ Spouse's Name: _____

Religious Preference: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____

EMPLOYMENT INFORMATION

Name of Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: () _____

- If you are retired, please provide retirement date: Month ____ Day ____ Year ____
- If you spouse is retired, please provide retirement date: Month ____ Day ____ Year ____

ACCIDENT INFORMATION

Was your injury an accident? Yes ___ No ___ If yes, please answer the following questions:

Date: ____/____/____ Time: _____ am/pm Location: _____ Description: _____

Work related: Yes ___ No ___ If yes, please answer the following questions:

Supervisor: _____ Phone () _____ Adjuster Info: _____

ADMISSION PROCESS

1. Initiates the Admission Data Base, the Transdisciplinary Discharge and the Interdisciplinary Teaching Record Planning information within 24 hours of admission or as soon as practical on adult medical surgical units.
2. Ask the patient/significant other if available, to assist with the completion of the Admission Data Base, Transdisciplinary Discharge Planning, and Interdisciplinary Teaching Record information.
3. Initiates the physical assessment within the time frame per structure standard using the Physical Assessment Protocol. Exceptions are noted on the Focus Notes.
4. Completes the skin assessment figure on the Admission Database. If an ostomy is present, an Enterostomal Therapy screening is entered on BCON. If wound or skin breakdown present, initiates the Standing Delegated Medical Orders for Skin and Wound Care.
5. Assures patient identification bracelet is on.
6. Assess pain.
Instructs on the use of the Pain Scale.
Circles the number corresponding to the intensity on the scale.
Identifies the patient unable to participate in the pain assessment.
7. Reviews the Nutrition/Metabolic screen on admission. Enters a Nutrition Evaluation on BCON if any of the criteria are marked yes or if patient has a Stage II or greater ulcer .
8. Reviews the Functional (Mobility/Activity) screen on admission.

INSTRUCTIONS:

If the patient checks "Yes" to an item, assess the patient and if needed request a physician order for Physical Therapy evaluation and treatment:

- Getting in and out of bed
- Coming to standing from chair/toilet
- Walking w/wo cane/crutches/walker
- Falls
- Dizziness/loss of balance

If the patient checks "Yes", assess the patient and if needed request a physician order for Occupational Therapy evaluation and treatment:

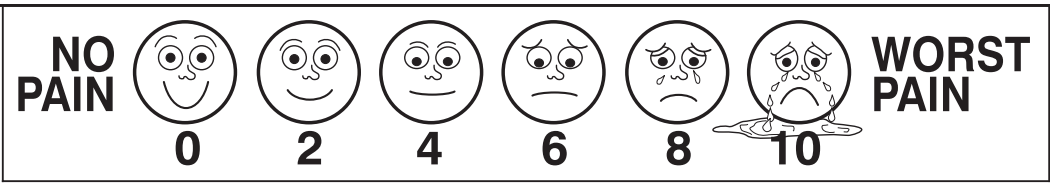
- Completing personal hygiene/grooming

If the patient checks "Yes", assess the patient and if needed request a physician order for Speech Therapy evaluation and treatment:

- Swallowing and communication

9. Notes allergies on: Admission Data Base, arm band, BCON and front of the chart.
10. Gives patient the Advanced Directive information. If patient cannot receive the information, gives to family/significant other and assesses periodically when patient can be given the information. Enters all on BCON.
11. Enter patient's height and weight on BCON
12. Reviews Immunization screen on admission. Initiates Standing Delegated Medical Order if appropriate.
13. Orients the patient or responsible party to:

Call light	Bed operation	Telephone
Visiting hours	Meal times	Smoking policy
Use of side rails	Valuables policy	Television
Room lights		
14. Initiates Focus List with appropriate goals.
15. Initiates CarePath if applicable
16. Reviews the Transdisciplinary Discharge Planning screening criteria and makes appropriate referrals. Places under the Discharge Planning tab in the chart.
17. Assess for Medical Alert condition on admission and enter on BCON if present.
18. Gives patient/family the Health Promotion Brochure and completes assessment of the Interdisciplinary Patient Teaching Record.
19. Reviews Suicide Ideation screen. Notifies attending physician to evaluate the patient for a Psychiatric Consult if the patient marks they are having thoughts of suicide or harming themselves.



ADMISSION DATA BASE INFORMATION

DIRECTIONS: PLEASE COMPLETE THE FOLLOWING. DO NOT COMPLETE AREAS OUTLINED WITH DASHED LINES.

I. HEALTH PERCEPTION AND HEALTH MANAGEMENT

What **HEALTH PROBLEM** brought you to the hospital? _____

Do you have a **HISTORY** of:

- Seizures No Yes
- Lung Disease No Yes
- Heart Attack No Yes
- Heart Disease No Yes
- Chest Pain No Yes
- Transplant _____ No Yes
- Gum Infection No Yes
- Dental Cavities No Yes

- Cancer No Yes
- Liver Disease/Hepatitis/Cirrhosis No Yes
- Kidney / Bladder Disease No Yes
- Stomach Disease No Yes
- Bowel Disease No Yes
- Sleep Apnea No Yes
- Use of BiPAP/CPAP No Yes
- Stroke No Yes
- Blood or Bleeding Disorders No Yes
- Increased Cholesterol No Yes

- Diabetes No Yes
- High Blood Pressure No Yes
- Are you now or could you be pregnant? No Yes
- Date of Last Menstrual Period _____
- Hemodialysis Patient No Yes
- Access Site _____
- Dialysis Schedule M W F T T H S
- Peritoneal Dialysis No Yes
- Dialysis Solution _____
- Dwell Time _____ Hrs.
- Number of Exchanges per day _____
- Methicillin-resistant Staphylococcus Aureus No Yes
- Vancomycin-resistant Enterococci No Yes
- Other (Specify): _____

List all **SURGERIES** you have had, including dates:

Previous Adverse Reaction to Anesthesia No Yes Describe _____

Do you have any **IMPLANTS / PROSTHETICS?** No Yes

If yes, please check those applicable:

- Lens Implants Pacemaker / Implantable Cardio Defibrillator Joint Replacement Pins / Rods Prosthetic Valves
- Implantable Pump / Devices _____ Medication Stent Location _____
- Tracheostomy Size _____ Other: _____

Have you smoked any type of tobacco (cigarettes, cigars, pipes) in the past twelve months?

- No Yes Within the last 30 days? No Yes

Have you used any type of smokeless product (chewing tobacco, snuff, chewing unlit cigar, dip) in the past twelve months?

- No Yes Within the last 30 days? No Yes

If you use tobacco products, have you been encouraged to quit and given written information about quitting?

- No Yes If yes, when? _____

If you use tobacco products would you be interested in an alternative nicotine product while in the hospital? No Yes

Patient received smoking cessation / prevention information at time of admission: No Yes

Do you drink **LIQUOR / BEER / WINE?** No Yes If yes, how much? _____ How Often? _____

Are you or any family member concerned about your alcohol use? No Yes

Are you interested in speaking with someone about available treatment options or resources? No Yes

IMMUNIZATIONS: Have you had the following immunizations ?

- Tetanus vaccine in the last 10 years No Yes
- Pneumococcal vaccine No Yes
- Hepatitis B vaccine No Yes
- Flu shot in the past year No Yes
- TB test within the past year No Yes
- If Yes, results were Positive Negative
- Have you ever received the Bacillus Calmette Guerin vaccine (BCG)? No Yes

MED REC NO. _____

PATIENT _____

PHYSICIAN _____

BILLING NO. _____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS



028735 (Rev. 04/09) (47415)

ADMISSION DATA BASE INFORMATION
ADULT MEDICAL SURGICAL PAGE 1 OF 4

Medication List

List all prescriptions, non-prescription, supplement and herbal supplements or routine medications taking

NO	NAME OF DRUG	DOSE AMOUNT	HOW MANY TAKEN	SCHEDULE	LAST DOSE	WHY TAKING WHY PRESCRIBED
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						

Not a Permanent Part of the Medical Record.

Revised 02/09

VII. PAIN ASSESSMENT

Are you having **PAIN / DISCOMFORT NOW?** No Yes
If yes, please describe: _____

Have you had recent **PAIN / DISCOMFORT?** No Yes
If yes, please describe: _____

If you are having pain or have recently experienced pain, please answer the following questions:

What was your worst pain in the last 24 hours? _____

Where is your pain located? _____

When did the pain start? _____

Is the pain constant or intermittent? _____

Any other associated symptoms? _____

What makes the pain better? _____

What makes the pain worse? _____

Have you experienced this pain before? No Yes

What treatments have you tried that makes the pain better? _____

What treatments have you tried that do not help your pain? _____

Is your pain affecting your daily activities? _____

Is your current level of pain acceptable? No Yes

Patient unable to participate in pain assessment? No Yes

Current PAIN (Circle one) **0 1 2 3 4 5 6 7 8 9 10**

Pain in the last 24 hours (Circle one) **0 1 2 3 4 5 6 7 8 9 10**

VIII. ROLE / RELATIONSHIP

Do you feel safe in your relationships at home? No Yes

Would you like information regarding family violence? No Yes

IX. COPING / STRESS

Any recent **CHANGES IN YOUR LIFE** related to your family, job, home, etc.? No Yes

If yes, please describe: _____

How do you cope with stress? _____

Are you feeling hopeless or worthless? No Yes

If yes, please answer the following question.

Are you having thoughts of suicide or harming yourself?
 No Yes

X. HEALTH PERCEPTION / HEALTH MANAGEMENT PATTERN

Please complete the following information to help us plan for your discharge.

Are you responsible for the care of anyone else? No Yes
If yes, whom? _____

Who will be helping with your care when you leave?
Name: _____

Relationship: _____ Phone: _____

Did any agencies or people help you with your care before you came to the hospital? (Home Health, neighbor, family, other)? No Yes

If yes, list Name/Agency: _____

Do you use any type of medical equipment? No Yes

If yes, check all that apply

BiPAP CPAP Walker
 Cane Crutches Wheelchair
 Commode Prosthesis Other _____

Do you anticipate returning home after this hospitalization? No Yes

If No, where do you anticipate going? _____

XI. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

If returning home, do you need help with any of the following activities?

Transportation – **driving or arranging for public transport** No Yes

Meal preparation – **plan and prepare a meal, use stove safely** No Yes

Shopping and Errands – **shop alone for groceries** No Yes

Household Chores – **wash dishes, sweep, mop** No Yes

Money Management – **pay bills, keep checkbook, manage affairs** No Yes

Medication Management – **know what each medication is for, when/how to take it** No Yes

Do you anticipate any needs at discharge? No Yes

XII. EMERGENCY CONTACTS

NAME/RELATIONSHIP	PHONE NUMBER
_____	_____
_____	_____
_____	_____

XIII. INFORMATION GIVEN BY

Informant _____

Date: _____ Time: _____ Relationship to Patient: _____

MED REC NO. _____

PATIENT _____

PHYSICIAN _____

BILLING NO. _____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS


028735 (Rev. 04/09)

ADMISSION DATA BASE INFORMATION
ADULT MEDICAL SURGICAL PAGE 3 OF 4 **D-202**

List all allergies / intolerances and reactions (food, drug, environmental, latex, iodine, shellfish, contrast medium.)

ALLERGY / INTOLERANCE	DESCRIBE REACTION

II. NUTRITION / METABOLIC

HEIGHT: _____ **CURRENT WEIGHT:** _____
(check all that apply)

Lost 10 pounds or more in the past month without trying No Yes

Poor appetite over the last month No Yes

Follow a lactose (milk) free or gluten (wheat) free diet No Yes

Patient in ICU, Oncology No Yes

Difficulty chewing or swallowing No Yes

Need education on current diet No Yes

Religious or cultural dietary requirements No Yes

On tube feeding/IV nutrition No Yes

Non-healing wound or pressure ulcer No Yes

III. ELIMINATION

Do you have any problems with **URINATION**? No Yes
If yes, specify: _____

Ostomy _____ No Yes
Type: _____

Do you have any problems with bowel movements? No Yes
 Diarrhea Other: _____ None of these
 Constipation

Specify: _____

Ostomy _____ No Yes
Type: _____

When was your **LAST BOWEL MOVEMENT**? _____

How often do you have **BOWEL MOVEMENTS**? _____

IV. MOBILITY / ACTIVITY

Over the **LAST TWO WEEKS**, have you developed any or greater difficulty with the following activities?

Getting in and out of bed No Yes

Coming to standing from a chair/toilet No Yes

Walking w/wo cane/crutches/walker No Yes

Falls No Yes

Dizziness/loss of balance No Yes

Completing personal hygiene/grooming needs No Yes

Swallowing or communication No Yes

V. COGNITIVE / PERCEPTUAL / EDUCATION

Do you have to **Wear**:
GLASSES / CONTACT LENSES? No Yes
HEARING AID? No Yes
If Yes, Left ear Right ear Both

What level of **EDUCATION** have you completed? _____

Do you **READ MAGAZINES, BOOKS, AND / OR NEWSPAPERS?** No Yes

How do you prefer to learn? Reading Hearing Watching Doing
(Mark all that apply)

Primary **LANGUAGE** spoken: _____

Interpreter Required? No Yes

Do you have changes in thought processes/behavior? No Yes
 Mental Status Memory (recent/remote) Learning Ability
 Decision making/judgement

VI. VALUE / BELIEF

Do you have a **RELIGIOUS, SPIRITUAL AND/OR CULTURAL TRADITION** we need to consider? No Yes
If yes, specify:

MED REC NO. _____

PATIENT _____

PHYSICIAN _____

BILLING NO. _____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS



028735 (Rev. 04/09)

ADMISSION DATA BASE INFORMATION
ADULT MEDICAL SURGICAL PAGE 2 OF 4

D-202

PHYSICAL ASSESSMENT

II Nutritional / Metabolic III Elimination	<p>INTEGUMENTARY Skin color normal for race/ethnic background. Warm, dry & intact.</p> <p>GASTROINTESTINAL Bowel sounds active in all 4 quadrants. Abdomen soft. No distention. No pain with light palpation (nontender). No nausea or vomiting. No stomas or wounds.</p> <p>GENITOURINARY Bladder evacuated without difficulty. No incontinence. No stomas. If Foley present, urine clear, yellow, and draining.</p> <p>INTRAVENOUS (peripheral or central, if applicable) IV fluid infusing well without difficulty or intermittent device (saline lock) flushes well. No redness or swelling noted at IV site. Site and tubing (if applicable) meet date requirements for change. Dressing on IV site is clean, dry, and intact.</p> <p>INCISION/WOUND (if applicable) Dressing, if present, is clean, dry, and intact. No evidence of redness, swelling, increased temperature, or pain in surrounding tissue. No purulent drainage. Sutures, staples, or steri strips are dry and intact with wound edges approximated. Pin site (if applicable) is clean, dry, and without evidence of purulent drainage. Tubes/drains (if applicable) are patent and activated.</p>
IV Mobility/Activity	<p>CARDIOVASCULAR Regular apical pulse 60 to 100. Peripheral pulses present & equal. Assessment as appropriate for patient condition. No edema. No chest pain. Blood pressure within normal limits for patient.</p> <p>RESPIRATORY Respirations 10 to 20 per minute at rest. Respirations regular. Lungs clear all lobes. Not using accessory muscles in respiratory effort. Nailbeds pink. No stomas.</p> <p>MUSCULOSKELETAL Moves all extremities. Gait & ambulation appropriate.</p>
V Cognitive/ Perceptual II Nutritional/ Metabolic	<p>EYE, EAR, NOSE & THROAT Able to read instructions. Able to hear instructions or conversation. Able to chew and swallow.</p>
V Cognitive/ Perceptual	<p>NEUROLOGICAL Alert & oriented to person, place & time. Behavior appropriate to situation. Speech clear & understandable.</p>

MEDICAL ALERT CONDITIONS

IF ANY OF THESE CONDITIONS ARE PRESENT ENTER ON BCON

- | | | | |
|--|--|---|--|
| <ul style="list-style-type: none"> • ALTERED MENTAL STATUS • AMPUTEE • ANTICOAGULANTS • ASTHMA • APHASIA • BLINDNESS | <ul style="list-style-type: none"> • DEAF • DIABETES • FALL PRECAUTIONS • HEARING IMPAIRMENT • HYPERTENSION • IMMUNOSUPPRESSED | <ul style="list-style-type: none"> • NO PERIPHERAL STICK OR BP MEASUREMENTS R OR L ARM • NO ENGLISH • MINIMAL ENGLISH • PACEMAKER | <ul style="list-style-type: none"> • PROSTHESES • SEIZURES • SIDUS INVERSUS (TRANSPOSITION OF ORGANS) |
|--|--|---|--|

ADVANCE DIRECTIVE TRACKING FORM

Dear Patient: Please complete the following questions. This form will become part of your medical record. We are required to obtain this information by our accreditation organization and by Federal Law.

1. Do you have any of the following Advance Directives (check all that apply)?

<input type="checkbox"/> Medical Power of Attorney	<input type="checkbox"/> Living Will
<input type="checkbox"/> Out of Hospital Do Not Resuscitate	<input type="checkbox"/> Mental Health Directive

2. If you have any of these documents and do not have a copy with you, where is it located? _____
 Can someone bring a copy to the hospital? yes no

3. If you do not have an Advance Directive and wish to complete one, we will provide you with the proper forms and other information needed to complete the directive.

4. If you have an Advance Directive but a copy is not available at this time, what does your Advance Directive say about your treatment wishes if you become terminally or irreversibly ill and are unable to make your wishes known?

5. If we are unable to communicate with you as a result of your illness, who should we speak with on your behalf?

Name	Relationship	Phone Number
------	--------------	--------------

6. I do not wish to make an Advance Directive at this time.

I am aware that if I become unable to make decisions for myself and I have not completed an Advance Directive, state law will require that my physicians turn to the following persons in the order listed for medical decision-making: my spouse, my reasonably available adult children, my parents, or my nearest living relative. If none of those persons are available or willing to act on my behalf, I am aware that state law allows my doctors to turn to the hospital's medical ethics committee or to a court of law for medical decision-making.

_____ Patient Signature _____ Date

This information will be available for your doctor. However, if you have questions or wish to discuss this further with him/her, please let us know.

For hospital staff use only: Please date the following when completed (if applicable):

Patient unable to discuss (re-assess daily).	<input type="checkbox"/> Advance Directive sticker placed in MD
Information given to family/surrogate.	<input type="checkbox"/> notes.
Advance Directive placed on medical record.	<input type="checkbox"/> Advance Directive information entered on BCON.
Personal choices brochure given	<input type="checkbox"/> Patient desired more information —
<input type="checkbox"/> to patient <input type="checkbox"/> to family	<input type="checkbox"/> referral to Pastoral Care made.

_____ RN Signature _____ Date
 _____ MD Signature _____ Date

MED REC NO. _____
 PATIENT _____
 PHYSICIAN _____
 BILLING NO. _____

BAYLOR UNIVERSITY MEDICAL CENTER
 Dallas, Texas



43385 (Rev. 3/04)

ADVANCE DIRECTIVE TRACKING FORM

TRANSDISCIPLINARY DISCHARGE PLANNING

SCREENING CRITERIA

PLEASE SEND REFERRAL TO SOCIAL SERVICES IF DISCHARGE PLANNING ASSISTANCE NEEDED.

Use as guide to determine the need for discharge planning, with consideration of physical, emotional, environmental and mental status needs at the time of discharge.

1. Age - 70 and over with inadequate home environment.
2. No known family, friends or method of follow-up contact.
3. Patients hospitalized due to non-compliance with medical regime.
4. Suicide risk gesture or attempt.
5. Admissions from or to Extended Care facility.
6. Admission for Rehabilitation Services outside BHCS.
7. Patients whose illness will necessitate a change in lifestyle, etc.
8. Admission diagnosis needing immediate discharge planning:
 - a. Aneurysm
 - b. Neurological disorders (spinal cord injuries, sub-arachnoid hemorrhage, sub-dural hematoma, brain tumor, coma).
 - c. CVA
 - d. Dementia (OBS or other mental debility)
 - e. Malnutrition/Dehydration
 - f. Pressure ulcers
 9. Hip fracture
 - h. Carcinoma
 - i. Chronic illness (COPD, CHF, etc.)
 - j. Multiple trauma
9. Hospice or Palliative Care referral
10. Transportation needs
11. Take home medication
12. Substance abuse
13. Suspected abuse or neglect
 - a. Untreated old injuries, multiple injuries in varying stages of healing.
 - b. Extent or type of injury is inconsistent with explanation patient gives, or there are conflicting histories of injury.
 - c. Injuries are on areas of the body normally covered by clothing.
 - d. History of being "accident prone", or having many previous injuries.
 - e. Describes the accident in a hesitant, embarrassed, or evasive manner.
 - f. Verbal or nonverbal indications of abuse, neglect, or domestic violence.
14. Indigent (Resources Unknown)
15. "John Doe"
16. Educational needs for children and adolescents
17. All transplants
18. Complex discharge planning needs
19. Numerous recent admissions
20. Ventilator dependent
21. Tracheotomy patient with need for long term care
22. Any criterion selected related to instrumental activities of daily living

CARE COORDINATOR REFERRAL:

IF NURSING ASSESSMENT DEMONSTRATED ANY OF THE FOLLOWING:

1. Age - 70 and over with inadequate home environment.
2. Admission diagnosis needing immediate discharge planning:
 - a. CVA, Myocardial Infarction
 - b. Head/Multiple Trauma, Spinal Cord
 - c. Injuries, Dementia
 - d. Carcinoma
 - e. Septicemia
 - f. Severe Activity limiting articular restriction, fractures, MS, amputation
 - g. Malnutrition/Dehydration
 - h. Pressure ulcers
 - i. Diabetes (newly diagnosed or with complications)
3. Complex Discharge Planning Needs
4. Chronic illness (COPD, CHF, HIV, Asthma (adult, child))
5. Numerous recent admissions
6. Patients hospitalized due to non-compliance with medical regime
7. Ventilator dependent patient
8. Tracheotomy patient with need for long term care
9. Home Health/Durable Medical Equipment
10. Acute care rehab needs within Baylor (BIR, BSH referrals)
11. Long Term IV Antibiotics
12. Patients needing take home meds.
13. Care path patients
14. All transplants

During your stay at Baylor, we would like to provide you with the following health promotion, risk management and wellness information to help you

maintain a healthy lifestyle.

HEART AND VASCULAR INFORMATION

Baylor Health Care System offers full-service heart and vascular services at a variety of Baylor locations.

Cardiovascular Disease

Risk Factors for Heart Attack and Stroke (also called Brain Attack)

Cardiovascular disease is the number one cause of all deaths in the United States, both in men and women. Becoming familiar with your risk factors, as outlined by the American Heart Association, can decrease your chance of having a heart attack or stroke.

Major Uncontrollable Risk Factors:

Although you cannot alter these risks, awareness of having them makes it even more important to manage your "controllable" risk factors.

- Heredity: Know your family history. You are at greater risk if your mother or sister had a heart attack before age 65, and father/brother before age 55. Also, African Americans, Mexican Americans, native Hawaiians and some Asian Americans have a higher risk of heart disease.

- Increasing Age: Men & women 65 years or older.
- Gender: Men are at greater risk, but cardiovascular disease is the leading cause of death for both men and women.

Risk Factors you can Modify:

- Tobacco use in any form, including exposure to second-hand smoke, can increase risk
- High Blood Cholesterol
- High Blood Pressure
- Physical Inactivity
- Obesity and Overweight
- Diabetes

If you are concerned about your risk factors, please discuss risk management with your health care provider. Call **1-800-4BAYLOR** for cardiovascular information. You can also call 1-800-AHA-USA1 for information on heart disease, or 1-888-4-STROKE for information on Stroke. On the Internet, go to (on back) www.americanheart.org* or www.LepforLife.com.

GENERAL WELLNESS INFORMATION

Substance Abuse

Substance abuse is alcohol or drugs (legal or illegal) taken in increasing amounts over a longer period than intended. Substance abuse does not necessarily mean you are addicted. If you think you might be addicted or abusing drugs or alcohol, please inform your nurse. We have licensed counselors to assist you. Call the Baylor Center for Psychiatry & Addictive Diseases at (214) 820-7676 or talk to your healthcare provider.

You may want to use this easy assessment ... it's the CAGE Assessment Tool

- C = Cutdown: Ever feel the need to cut down?
- A = Annoyed: Ever feel annoyed by criticism from others about drinking/drugs?
- G = Guilty: Ever felt guilty about drinking/drugs?
- E = Eye-opener: Ever drank/used drugs to get going in the morning?

Family Violence

Many people associate abuse with physical violence only. Abuse also can be verbal or emotional. Abuse

in any form is an action of control. Your physician, nurse or social worker can provide you with more information, a safety plan and available community resources. If you have needs, please ask for the telephone number of the Social Work Department at your Baylor facility or call **1-800-4BAYLOR** and ask for the Social Work Department.

Immunization

Immunizations can protect against many diseases in adults as well as children. Diseases such as hepatitis, influenza, pneumonia, tetanus, mumps, measles, and rubella can be prevented or the effects lessened with vaccination of the adult patient. Children have specialized immunization needs for prevention of childhood diseases. Check with your family doctor if you think you or your child need immunizations.

Contact Centers for Disease Control and Prevention at 1-800-232-2522 (English) 1-800-232-0233 (Spanish) CDC website at www.cdc.gov.nip*

Mental Health

There is always an emotional/psychological component to every illness or hospitalization. If you or your family member needs assistance, do not hesitate to notify your nurse, primary care provider or social worker. You may also call the Baylor Center for Psychiatry & Addictive Diseases at (214) 820-7676.

Tobacco Cessation

Giving up the use of ALL tobacco products is one of the most important things you can do to improve your health and the health of those around you. Tobacco products include cigars, cigarettes, chew, dip and snuff. Nicotine, which is addictive, is in all forms of tobacco. Nicotine is what can make quitting so difficult. The good news is that help is available. If you are interested in learning more, please speak with your healthcare provider.

CANCER INFORMATION

Baylor Cancer Centers treat all forms of cancer. For information, referrals or services, please call 1-800-4BAYLOR or talk with your healthcare provider. You may access the American Cancer Society on the internet at www.cancer.org*

Breast Cancer

Baylor follows the American Cancer Society (ACS) guidelines** for breast cancer screening of women without symptoms:

- A mammogram every year for all women age 40 or older (screening may begin earlier if clinically indicated).
- Clinical breast exam by a health care professional every 3 years for women age 20 to 39, and annually for women age 40 and older.
- Breast self-exam monthly for all women age 20 and older.

** Guidelines for screening without symptoms of breast disease and with normal risk for cancer. The presence of a strong family history of breast cancer or other factors may alter these recommendations. Please check with your healthcare provider if you need direction to the most convenient Baylor Cancer Center.

Colorectal Cancer

Baylor follows the American Cancer Society guidelines for early detection of colorectal cancer. Beginning at age 50, men and woman should have a fecal occult blood test and flexible sigmoidoscopy. Repeat the fecal occult blood test annually and the sigmoidoscopy every 5 years, or have a colonoscopy at 10-year intervals, or have a double-contrast barium enema every 5 to 10 years. You may ask your healthcare provider for further information.

Pap Test

The Pap test can detect early, "pre-cancerous" cell changes in the cervix. Baylor follows the American Cancer Society recommendations that all women who have reached the age of 18 or have been sexually active have a Pap test and pelvic exam every year. Please discuss any questions with your healthcare provider.

Prostate Cancer

Baylor follows the American Cancer Society guidelines for early detection of prostate cancer. Men should have a prostate-specific antigen (PSA) blood test and digital rectal exam (DRE) every year, starting at age 50.

African-American men and men who have two or more close relatives (father or brothers) with prostate cancer should begin screenings at age 45.

Skin Cancer

Baylor recommends avoiding prolonged exposure to the sun, especially during the midday. These actions can help prevent most skin cancers. Wear protective clothing—hats with brims, long-sleeved shirts—and use sunscreen on all exposed parts of the skin. If you have children, protect them from the sun and don't allow them to become sunburned. Examine your skin regularly for irregular moles, and have a skin exam during your regular health checkups.



BAYLOR HEALTH CARE SYSTEM

Baylor hopes you have found these wellness tips helpful. As a leader in cancer, heart, and vascular care, Baylor provides a variety of services from prevention to clinical research. If you need more information regarding good health tips or illness prevention, please call **1-800-4BAYLOR** or visit www.baylorhealth.com.

*Baylor does not own or produce these websites. However, as a public service to you, Baylor is providing you with this resource information. Baylor does not sponsor or endorse the websites or the contents of the websites. If you have any questions, please contact your healthcare provider.