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,

John B. McWhorter, III
President
**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? _____________________________________________________________

<table>
<thead>
<tr>
<th>Do you have a HISTORY of:</th>
<th>Yes</th>
<th>No</th>
<th>Within the last 30 days?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Chest Pain</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Transplant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gum Infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Cavities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver Disease/Hepatitis/Cirrhosis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Kidney / Bladder Disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stomach Disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bowel Disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Use of BiPAP/CPAP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stroke</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood or Bleeding Disorders</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Increased Cholesterol</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

| Diabetes                    | Yes | No |
| High Blood Pressure          | Yes | No |
| Are you or could you         | Yes | No |
| be pregnant?                 |     |    |
| Date of Last Menstrual Period|     |    |
| Hemodialysis Patient         | Yes | No |
| Access Site                  |     |    |
| Dialysis Schedule            |     |    |
| M W F T TH S                 |     |    |
| Peritoneal Dialysis          | Yes | No |
| Dialysis Solution            |     |    |
| Methicillin-resistant        | Yes | No |
| Staphylococcus Aureus        | Yes | No |
| Vancomycin-resistant         | Yes | No |
| Enterococci                  | Yes | No |

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

**Previous Adverse Reaction to Anesthesia** No Yes Describe _____________________________________________

<table>
<thead>
<tr>
<th>Do you have any IMPLANTS / PROSTHETICS?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lens Implants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacemaker / Implantable Cardio Defibrillator</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Implantable Pump / Devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mediation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pins / Rods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic Valves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracheostomy Size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you smoked any type of tobacco (cigarettes, cigars, pipes) in the past twelve months?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the last 30 days?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you used any type of smokeless product (chewing tobacco, snuff, chewing unlit cigar, dip) in the past twelve months?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the last 30 days?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If you use tobacco products, have you been encouraged to quit and given written information about quitting? Yes No

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

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

<table>
<thead>
<tr>
<th>Do you drink LIQUOR / BEER / WINE?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, how much?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How Often?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

**IMMUNIZATIONS:** Have you had the following immunizations?

<table>
<thead>
<tr>
<th>Tetanus vaccine in the last 10 years</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu shot in the past year</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pneumococcal vaccine</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>TB test within the past year</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, results were</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever received the Bacillus Calmette Guerin vaccine (BCG)? Yes No

---

**BAYLOR UNIVERSITY MEDICAL CENTER**

**DALLAS, TEXAS**

---

**MED REC NO.**

**PATIENT**

**PHYSICIAN**

**BILLING NO.**
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


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. Orient the patient or responsible party to:
   Call light
   Visiting hours
   Use of side rails
   Room lights

   Bed operation
   Meal times
   Valuables policy
   Telephone
   Smoking policy
   Television

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.

<table>
<thead>
<tr>
<th>NO PAIN</th>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
<th>WORST PAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Pain</td>
<td>Mild Pain</td>
<td>Pain</td>
<td>Very</td>
<td>Worst</td>
<td>Possible</td>
<td></td>
</tr>
</tbody>
</table>

BAYLOR UNIVERSITY MEDICAL CENTER
An Affiliate of Baylor Health Care System
### IV. MOBILITY / ACTIVITY

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting in and out of bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coming to standing from a chair/toilet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking w/wo cane/crutches/walker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness/loss of balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completing personal hygiene/grooming needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swallowing or communication</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. ELIMINATION

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any problems with URINATION?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, specify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#Stomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any problems with bowel movements?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ostomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your LAST BOWEL MOVEMENT?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have BOWEL MOVEMENTS?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### II. NUTRITION / METABOLIC

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEIGHT:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CURRENT WEIGHT:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### V. COGNITIVE / PERCEPTUAL / EDUCATION

Do you have a RELIGIOUS, SPIRITUAL AND/OR CULTURAL TRADITION we need to consider?  
If yes, specify:

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RELIGIOUS, SPIRITUAL AND/OR CULTURAL TRADITION</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### VI. VALUE / BELIEF

Do you have a religious, spiritual and/or cultural tradition we need to consider?  
If yes, specify:

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RELIGIOUS, SPIRITUAL AND/OR CULTURAL TRADITION</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## PHYSICAL ASSESSMENT

### INTEGUMENTARY
Skin color normal for race/ethnic background. Warm, dry & intact.

### 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.

### GENITOURINARY
Bladder evacuated without difficulty. No incontinence. No stomas. If Foley present, urine clear, yellow, and draining.

### 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.

### 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 steristrips 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.

### 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.

### RESPIRATORY

### MUSCULOSKELETAL
Moves all extremities. Gait & ambulation appropriate.

### EYE, EAR, NOSE & THROAT
Able to read instructions. Able to hear instructions or conversation. Able to chew and swallow.

### NEUROLOGICAL
Alert & oriented to person, place & time. Behavior appropriate to situation. Speech clear & understandable.

## MEDICAL ALERT CONDITIONS

**IF ANY OF THESE CONDITIONS ARE PRESENT ENTER ON BCON**

- ALTERED MENTAL STATUS
- AMPUTEE
- ANTICOAGULANTS
- ASTHMA
- APHASIA
- BLINDNESS
- DEAF
- DIABETES
- FALL PRECAUTIONS
- HEARING IMPAIRMENT
- HYPERTENSION
- IMMUNOSUPPRESSED
- NO PERIPHERAL STICK OR BP MEASUREMENTS R OR L ARM
- NO ENGLISH
- MINIMAL ENGLISH
- PACEMAKER
- PROSTHESES
- SEIZURES
- SIDUS INVERSUS (TRANSPOSITION OF ORGANS)
### 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 [ ]

### VIII. ROLE / RELATIONSHIP

- **Do you feel safe in your relationships at home?**
  - No [ ] Yes [ ]
- **Would you like information regarding family violence?**
  - No [ ] Yes [ ]
- **How do you cope with stress?** ____________________________

### IX. COPING / STRESS

- **Any recent CHANGES IN YOUR LIFE related to your family, job, home, etc.?**
  - No [ ] Yes [ ]
  - If yes, please describe: ____________________________

- **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 [ ]
- **Meal preparation** – plan and prepare a meal, use stove safely [ ]
- **Shopping and Errands** – shop alone for groceries [ ]
- **Household Chores** – wash dishes, sweep, mop [ ]
- **Money Management** – pay bills, keep checkbook, manage affairs [ ]
- **Medication Management** – know what each medication is for, when/how to take it [ ]
- **Do you anticipate any needs at discharge?**
  - No [ ] Yes [ ]

### XII. EMERGENCY CONTACTS

**NAME/RELATIONSHIP**

**PHONE NUMBER**

<table>
<thead>
<tr>
<th>NAME/RELATIONSHIP</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### XIII. INFORMATION GIVEN BY

- **Informant** ____________________________
- **Date:** ____________________________
- **Time:** ____________________________
- **Relationship** ____________________________
- **to Patient:** ____________________________
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
   c. CVA
   d. Dementia (OBS or other mental debility)
   e. Malnutrition/Dehydration
   f. Pressure ulcers
   g. 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
XIV. MRSA SCREENING

Do you have any of the following:

- Hospitalization within the past year
- Transferred from an extended care facility
- Currently have open or draining skin wounds
- Currently on dialysis
- Currently admitted to Intensive Care Unit

XV. SCREENINGS (To be completed and entered into BCON by the Nurse)

- Advance Directives
- Allergies/Allergy Identification Bracelet Applied
- Care Coordination
- Care Path Initiated
- Enterostomal Therapy (ostomy only)
- Immunizations (Initiates Standing Delegated Medical Orders For Immunization)
- MRSA Screen (Obtains nasal swab if patient answers yes to any of the screening questions)
- Nutrition (complete on admission)
- Physical Medicine (complete on admission)
- Social Work
- Suicide Ideation

XVI. NOTES

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XVII. PERSONAL BELONGINGS (To be completed by the Nurse)

Only indicate the belongings the patient has with them with checkmarks

Fill in appropriate boxes

- ED
- Room
- Family
- BUMC Cashier
- Other

☐ Belongings collected in the ED

XVIII. SKIN ASSESSMENT (To be completed by the Nurse)

DIAGRAM CODES

- Abrasions - A
- Burns - B
- Contusions - C
- Erythema - E
- IV-Access - I
- Laceration - L
- Mottled - M
- Ostomy - O
- Petechia - P
- Rash - R
- Scar - S
- Ulcer - U

☐ Skin Assessment

Within Normal Limits

XIX. INFORMATION OBTAINED BY

Nurse Signature

Initials

Date: Time:

Nurse Signature

Initials

Date: Time:

Legend:  BCON = Baylor Computer Online Network  BHCS = Baylor Health Care System  BIPAP = Bi-Level Positive Airway Pressure  BIR = Baylor Institute for Rehabilitation  BSH = Baylor Specialty Hospital  CHF = Congestive Heart Failure  COPD = Chronic Obstructive Pulmonary Disease  CPAP = Continuous Positive Airway Pressure  CVA = Cerebrovascular Accident  ED = Emergency Department  F = Friday  HIV = Human Immunodeficiency Virus  ICU = Intensive Care Unit  IV = Intravenous  L = Left  M = Monday  MRSA = Methicillin Resistant Staphylococcus Aureus  MS = Multiple Sclerosis  OBS = Organic Brain Syndrome  R = Right  S = Saturday  Th = Thursday  TB = Tuberculosis  T = Tuesday  W/Wo = with/without  W = Wednesday

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

MED REC NO.  

PATIENT  

PHYSICIAN  

BILLING NO.  

028735 (Rev. 04/09)

ADMISSION DATA BASE INFORMATION
ADULT MEDICAL SURGICAL PAGE 4 OF 4  D-202
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)?
   _____ Medical Power of Attorney       _____ Living Will
   _____ Out of Hospital Do Not Resuscitate       _____ 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 __________________

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

   ____ Advance Directive sticker placed in MD notes.
   ____ Advance Directive information entered on BCON.
   ____ Patient desired more information — referral to Pastoral Care made.

   RN Signature __________________________ Date __________________
   MD Signature __________________________ Date __________________
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.

**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.LeapforLife.com.

**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*

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*CDC website at www.cdc.gov nip*
**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.

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**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.

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**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*.

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**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.

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**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.