ADDRESSOGRAPH

ST. FRANCIS SPECIALTY HOSPITAL, INC
TRANSDISCIPLINARY FORM

Name:_____ SS#_____ Admission Date_____ Time_____

Est. D/C Date:_____

Age:_____ DOB:_____ Referring M.D._____ Family M.D._____

Address_____ Telephone_____

_____ Admitted From_____

Marital status: M S D W Sep # Children:_____

Diagnosis:_____

_____

_____ Date of onset:_____

Contact Person:_____ Relationship_____ Phone#_____

Contact Person:_____ Relationship_____ Phone#_____

INSURANCE:

(Primary)_____

(Secondary)_____

ORIENTATION TO UNIT:

_____Call Light _____Side Rails _____TV _____Bed Control _____Phone _____Clothing needed

_____Family Conference _____Smoking Policy _____Visiting hours _____Family Training _____CRT

_____ADL Apt. _____Daily Schedule _____Team Therapy

Allergies_____

Vital Signs - B/P - Rt._____ Lt._____ T_____ P_____ R_____

Height_____ Weight_____

Disposition of Meds: Identified_____ Sent home_____ Not applicable_____

Ever received blood?_____ if yes, reaction?_____ Blood type_____

Power of Attorney/Living Will: Form completed_____ Form signed_____ Dr. aware_____ Referrals_____

Interest in Organ Donation?_____

Source: Sample page of revised form, St. Francis Specialty Hospital, Monroe, LA. Reprinted with permission.

Code Status

REASON FOR ADMISSION: (Stated in patient's own words)

DIAGNOSIS

SOURCE OF INFORMATION
__Patient __Referring material __Spouse __Son __Daughter ____Other

ADMITTED FROM
__SFMC __Home __SNF _____Other

ADMIT DATE/TIME
/ / hrs

MODE OF ADMISSION
__Auto __Stretcher __Amb. __W/C __Bed

ALLERGIES
Medications

DESCRIBE REACTION

__No known Allergies

Foods

Latex Sensitive __y __n

Other

Temp: Oral Rect. Axill. Typ

Pulse A P

Resp Rate

B/P / L / R __Supine __Sitting __Stand

Height

Weight _____ Bed scale
_____ W/C scale
_____ Stding scale

BLOOD
__Ever received blood
if yes, reaction?
Blood Type

Organ Donor
__Yes __No

GENERAL INFORMATION
Age _____ Marital: __S __W __D __M
Primary Language
Culture/Religion practices significant to Health Care

DENTURES Fit __Yes __No __Full __Partial
With patient: __Y __N __N/A

HEARING AID __N/A
Hearing Aid __N/A With patient __Y __N __L __R
GLASSES __N/A With patient __Y __N
Contact Lenses __N/A With patient __Y __N

__Valuables sent to Security
__ Brought X-rays __Y __N
Communication __Normal _Slurred _Nonverbal
Hand Dominanace __R __L

ORIENTATION TO UNIT
__Call light __Side rails __Family Conference __Bed Control
__Daily Schedule __Team Therapy __Family Training __TV __ADL apt.
__Smoking Policy __Visiting hours __Phone __CRT __Clothing Needed

MEDICAL PROBLEMS **A=Active** **H=History of** **P=Potential**

__Anemia	__ERSD	__Kidney disease	__RH Arthritis
__Cancer	__Emphysema	__Liver disease	__Seizure
__COPD	__GI problems	__Lung disease	__TB
__Cognitive/emot.prob.	__GYN problems	__Oteoarthritis	__Ulcer
__CVA	__Heart disease	__MRSA Site _____	__Urinary problems
__Diabetes	__Hypertension	__VRE Site _____	__Ostomy
__Dysreflexia	__Hypotension/Orthost.	__Psyc. trt.	__other

Alcohol consumption: __daily __weekly __monthly Other drug use _____
Tobacco use: __1-2 pk/day __more than 2 pk/day __Prior tobacco use __Other __N/A

Smoking Cessation Program Offered: __N/A __Patient desires program __Patient declines program

__Difficulty sleeping at night __Early or midnight awakening __Staying asleep __Night mares

LEVEL OF CONSCIOUSNESS
Oriented: __person __place __time __situation
__appropriate __alert __agitated __combative __confused
__drowsy __labile __somulent

PUPIL SIZE/REACTION
__Equal __Wide __Fixed
__Unequal __Reactive __Sluggish
__Pinpoint __Non-Reactive

GLASGOW COMA SCALE: 3 4 5 6 7 8 9 10 11 12 13 14 15 N/A

Completed by: _____

ST. FRANCIS SPECIALTY HOSPITAL
Monroe, LA
INTERDISCIPLINARY ASSESSMENT
FORM # 6224A REV 8/00 PAGE 1 of 12

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