

University of Louisiana at Lafayette
College of Nursing and Allied Health Professions
Department of Nursing

NURSING ASSESSMENT TOOL

**NURSING COURSES
208, 308, 403 & 418**

Student: _____ **Date:** _____

Patient's Age: <6mos/7-12 months/13-24 months/2-4 years/4-6 years/6-8 years/8-12 years /13-16 years/
 16-18 years / 18-40 years/41-59 years/60-69 years/70-79 years/80-89 years/90 and older
 Gender: Male Female
ALLERGIES (Drugs, food, tape, dyes, latex, etc.) yes no (If yes) Specify: _____
 Describe reaction(s) _____ Current LOS _____
 Reason for admission _____ Admit diagnosis _____
 Surgeries/Procedures (current) _____
 Other medical diagnoses _____
 Previous hospitalizations/surgeries/year _____
 Ancillary consults (therapy, dietary, social services, child life, etc.) _____
Advanced Directives: Living will DNR Other _____ Isolation: yes no (If yes) type _____
 Restraints in use: yes no (If yes) Restraint protocol _____ *see attached

HEALTH PERCEPTION/HEALTH MAINTENANCE PATTERNS

General appearance _____ Immunizations up-to-date: yes no If no, explain _____
 Received the Flu vaccine yes no TDAP yes no Pneumonia Vaccine yes no
 Recent illness/exposure to communicable disease _____
 Strategies done to manage health _____ Motivation _____
 Use of: Tobacco yes no (If yes) How long _____ How much _____
 ETOH yes no (If yes) How long _____ How much _____
 Other illicit substance(s) use/ Range: <1 day/1-6 days/2-4 weeks/3 months/4-6 months/6months
 Complementary Alternative Medicine (CAM) use/ Range: <1 day/1-6 days/2-4 weeks/1-3 months/4-6 months/>6months

MEDICATIONS (CURRENT PRESCRIPTION, OTC, & CAM)

Drug/Dosage/Route/Frequency	Drug/Dosage/Route/Frequency	Drug/Dosage/Route/Frequency

Home medication compliance/noncompliance _____ *see attached

LABORATORY DATA (Identify labs: High=H, Low=L, Critical =C, *** = Trend)

blanks are for other pertinent labs

Test:↓Date: →	Day 1	Day 2	Day 3	Current:	Test:↓Date:→	Day 1	Day 2	Day 3	Current:
RBC					Na				
WBC					K				
Hemoglobin					BUN				
Hematocrit					Creatinine				
Platelets					Glucose				
INR					Triglycerides				
PT					Total Chol.				
PTT					HDL/LDL				
Albumin					BNP				
					CO ₂				

MICROBIOLOGY CULTURE RESULTS				VITAL SIGN FLOWSHEET				
Specimen	24 hour results	48 hour results	72 hour results		Day 1	Day 2	Day 3	Current:
Urine				HR				
Sputum				BP				
Blood				RR				
Wound				Temp/Route				
CSF				SpO ₂				
Other								

DIAGNOSTIC TESTS
(Admit, Day 1, Day 2, Day 3, Current/RESULTS)

*blanks are for other diagnostic tests

Chest X-ray _____
 EKG _____
 CT scan _____
 MRI _____
 Ultrasound _____
 Other _____ *see attached

NUTRITIONAL/METABOLIC PATTERNS/INTEGUM

ID Wounds (with number to refer to in the form), IV sites, incisions, drains, etc.

Height _____ Current weight _____ Admit weight _____ BMI _____
 Last 3 daily weights _____

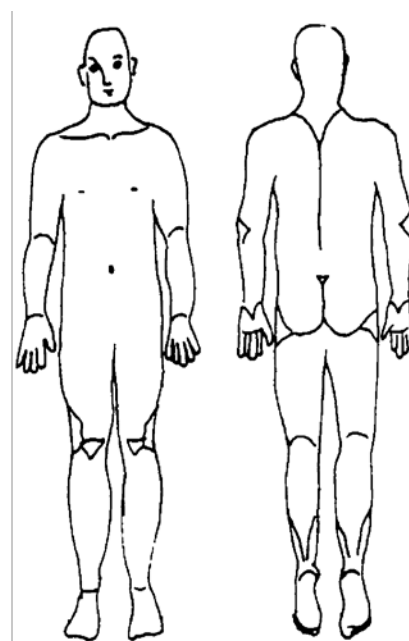
Current diet _____
 Supplements _____ Restrictions _____
 Pattern of intake at home _____
 Appetite _____ Anorexia _____ Nausea/vomiting _____
 Energy level _____ Recent wt. loss/gain _____

Condition of mouth/throat _____
 Difficulty swallowing _____ Problems chewing _____
 Dentures: None Full Partial Wears them? yes no
 Restrictions: NPO _____ Fluid Restriction _____

Upper GI distress (describe) _____

NG/PEG/Dobhoff (circle one) suction _____ character _____
 Enteral nutrition (type/rate) _____ Flush _____
 Tube feeding residuals _____
 TPN (type/rate) _____
 IV fluids (type/rate) _____

Skin: Moisture _____ Turgor _____ Bruises _____ Pruritus _____
 Edema _____ Incisions _____ Rash _____
 Wounds _____



IV sites -- Type: _____ Central _____ PICC _____ #1 Peripheral _____ #2 Peripheral

Condition: _____

Dialysis access sites _____ Thrill _____ Bruit _____

Orthopedic devices _____

Other data _____ *see attached

INTAKE	Admit	Day 1	Day 2	Day 3	Day 4
Oral					
IV Fluids					
Tube feeding					
*					
24 hr total					

OUTPUT	Admit	Day 1	Day 2	Day 3	Day 4
Urine					
NG					
Stool					
Drain 1					
Drain 2					
Dialysis					
Diaper					
*					
24 hr total					

Running Balance (difference in total intakes and total outputs since admission) (+ / -)

*Indicate other intake/output; Stool (liquid/colostomy) _____ *see attached

ELIMINATION PATTERNS

Bowel habits: #BMs/day _____ Last BM <24 hours/25-36 hours/37-48 hours/>2 days

Usual pattern _____ color _____ consistency _____

Constipation _____ Diarrhea (#/day) _____ Incontinence _____ Flatus _____ Occult blood _____ Recent changes _____

Ostomy: Type _____ Appliance _____ Self-care? _____

Stoma condition _____ Stool appearance _____

Use of laxatives, enemas, etc. (what & how often) _____

Abdominal PE: Contour _____ Firmness _____ Pain _____ Bowel sounds _____ Quads _____ Describe _____

Abd girth _____ Ascites _____ Other _____

Bladder habits: WNL _____ Frequency _____ Dysuria _____ Nocturia _____ Urgency _____ Hematuria _____ Retention _____

Incontinent: Yes No (if yes): Always Occasional Daytime Nighttime Difficulty reaching toilet

Assistive devices: Catheter _____ Diapers _____ Comments _____

Urine: Color _____ Odor _____ Clarity _____ Sediment _____

Dialysis : Yes No (if yes) type _____ how often _____

Other pertinent data _____ *see attached

ACTIVITY – EXERCISE PATTERNS

Activity level/pattern (prior to admit) _____ Exercise habits _____

History of physical disability _____ Uses assistive devices _____

Current activity level (orders) _____ Falls risk rating _____ Restraints _____

Range of motion: Full _____ Other _____

Ability to walk _____ Balance and gait: Steady _____ Unsteady _____

Casts/splints/braces _____ Fractures/contractures/arthritis/other _____

Verbalizes fatigue or weakness _____ General _____ Focal _____

Observed responses to activity (SOB, inc. pulse, B/P, etc.) _____ SPO₂ : Before _____ After _____ *see attached

ADL STATUS*

*Feeding _____ *Meal preparation _____ *Cleaning _____ *Bathing _____ *Dressing _____

*Grooming _____ *Toileting _____ *Shopping _____ *Laundry _____

Handedness: Right Left Able to use? _____

Physical or Occupational Therapy consult _____

Other pertinent data _____

***ADL Code (current status):**

- 0 Total independence
- 1 Requires device assistance
- 2 Requires 1 person assistance
- 3 Requires device and person assistance
- 4 Total dependence

CARDIOVASCULAR STATUS

BP: RA _____ LA _____ Sitting _____ Lying _____ Standing _____

Pulse: Apical _____/min Radial _____/min Strong _____ Weak _____

Peripheral: pulses: R upper: _____ L upper: _____ R lower: _____ L lower: _____

Nail bed color _____ Capillary refill _____ Temperature _____ Moisture _____

Edema _____ Sensation _____ JVD _____

Skin color: WNL _____ Pale _____ Cyanotic _____ Flushed _____ Other _____

Mucous membranes: Pink _____ Pale _____ Cyanotic _____ Other _____

Heart sounds: _____ S3 _____ S4 _____ Other _____ Hx of murmur _____ A-V bruit _____

Pacemaker _____ If yes, type & settings _____

Telemetry Yes No (if yes) cardiac rhythm _____

DVT prophylaxis regimen (describe) _____

Other pertinent data _____

*see attached **RESPIRATORY STATUS**

Rate _____ Quality: Depth _____ Rhythm _____ Accessory use _____

Retractions: Type _____ Severity _____

SOB on exertion (type activity) _____ SOB at rest _____ Cough _____ Sputum (describe) _____

Best position for breathing _____ O2 supplements _____

Breath sounds: (describe all lung fields): R upper anterior _____ R lower anterior _____

L upper anterior _____ L lower anterior _____

R upper posterior _____ R lower posterior _____

L upper posterior _____ L lower posterior _____

Airway adjuncts _____

Secretions _____

Chest tubes: location _____ settings _____ drainage _____

ABGs: pH _____ PO₂ _____ PCO₂ _____ Bicarb (HCO₃) _____ O₂ Sat _____

Other pertinent data _____

*see attached **SLEEP-REST PATTERNS**

Usual patterns: hours/night _____ AM nap _____ PM nap _____ Bedtime rituals/sleep patterns _____

Problems: Recent changes _____ Insomnia _____ Snoring _____ Hypersomnia _____

Sleep Apnea _____ Nightmares _____ Other _____

Sleeps in: Crib _____ Bed _____ Specialty Bed _____

Other pertinent data _____

*see attached **COGNITIVE/PERCEPTUAL PATTERNS****COGNITION**

Level of education _____ Primary Language _____ Able to speak English _____

Abnormal thought processes _____ Memory loss (short/long term) _____

Meeting Developmental Milestones _____

Other pertinent data _____

*see attached **SENSATION**

Hearing: WNL _____ Impaired _____ Deaf _____ Hearing aid _____ Tinnitus _____

Vision: WNL _____ Impaired _____ Glasses _____ Contact lenses _____ Cataracts _____

Prosthesis(R/L) _____ Lens implants(R/L) _____ Glaucoma _____

Taste: WNL _____ Impaired _____

Smell: WNL _____ Impaired _____

Touch: WNL _____ Impaired _____

Numbness/tingling _____ Dizziness _____ Vertigo _____

Other pertinent data _____

*see attached

NEURO SENSORY

Mental Status: Alert _____ Oriented (x ___) _____ Receptive aphasia _____ Confused _____ Combative _____

Obtunded _____ Unresponsive _____

Speech: WNL _____ Slurred _____ Garbled _____ Expressive aphasia _____

Pupils: Equal ___ Unequal ___ Size: (R) _____ (L) _____ React to light: (R) _____ (L) _____ Accommodation _____
Other (surgeries, etc) _____

Reflexes: DTR's: _____

Superficial: _____

Movement & strength of extremities: R upper _____ L upper _____ R lower _____ L lower _____

Seizure activity _____ Type _____

Fontanel (infants only): soft/flat _____ full/tense _____ depressed _____

Restraint Use _____

Other pertinent data _____ *see attached **PAIN/COMFORT**

Acute pain: location _____ intensity (rating) _____ quality _____ duration _____ pattern _____

Chronic pain: location _____ intensity (rating) _____ duration _____ pattern _____

Type of Pain Scale _____ Precipitating factors _____ Aggravating factors _____

Accompanying symptoms _____

Pain relief measures (type, how often) _____

Satisfaction with relief (pain rating, etc.) _____

PCA pump (medication, dosage, pump settings) _____

Other discomforts _____ Relief measures _____

Other pertinent data _____ *see attached **SELF PERCEPTION/SELF CONCEPT/COPING-STRESS TOLERANCE PATTERNS**

Major concerns regarding hospitalization/illness/perceived self-concept _____

Major losses in last year _____ Major life changes in last year _____

Body image changes _____ Change in abilities/role _____

Emotional state: Calm ___ Cheerful ___ Euphoric ___ Anxious ___ Withdrawn ___ Sad ___ Irritable ___ Demanding ___

Stressors _____

Usual methods for stress management _____

Relaxation techniques _____

Other pertinent data _____ *see attached **SEXUAL/REPRODUCTIVE PATTERNS**Female: Pregnancies _____ Children _____ LMP <7 days/8-14 days/15-30 days/>30 days Menopause yes no

Menstrual problems _____

Last mammogram _____ Monthly self-breast exams: yes no Last pap smear _____

Vaginal discharge _____ Lesions _____ Bleeding _____

Male: Last prostate exam 1-6 months/6-12 months/1-2 years/> 2 years. Monthly self-testicular exam: yes no

History of STI _____

Sexual concerns _____

Other pertinent data: _____ *see attached

ROLE-RELATIONSHIP PATTERNS

Occupation: _____ Employment status _____
Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
Support systems: Spouse _____ Family in same residence _____
Family not in residence _____ Neighbors/friends _____
Parents Involved(if patient is a minor) _____ Visiting _____
Educational level: _____ Educational level of parent (if patient is a minor) _____
Family concerns regarding hospitalization: _____
Changes in roles/relationships _____
Other pertinent data: _____ *see attached

VALUE-BELIEF PATTERNS

Cultural/ethnic background _____ Denomination _____
Life goals/values _____
Spiritual values/beliefs which influence health _____
Request pastoral care/support person _____
Other pertinent data: _____ *see attached

DISCHARGE PLANNING & TEACHING NEEDS

Anticipated D/C date: discharged in <1 day/discharged in 1-3 days/cannot anticipate discharge date
Discharged to _____ Lives with _____
Major caregiver _____ Available help at home _____
Anticipated self-care problems post-discharge _____
Previous use of community resources _____
Insurance Status: _____ Assistive devices needed _____
Home Medical Equipment _____
Need for community resources post discharge _____
Referrals made at discharge: (record date) _____

Other pertinent data: _____ *see attached

TEACHING NEEDS:

- (1) _____
- (2) _____
- (3) _____
- (4) _____

*see attached