BOARDER PATIENT RN-LPN SHIFT ASSESSMENT	
Date:	**Time of Assessment:**
Shift: ☐7-3 ☐3-11 ☐11-7 ☐0700-1900 ☐1100-2300 ☐2300-1100 ☐1500-1900	
LEVEL OF CARE	
What is the LEVEL OF CARE of this patient? (ie. ICU LEVEL, TELEMETRY LEVEL)	_____
LANGUAGE	
Is the preferred language used during the shift in explaining patient's healthcare needs?	☐Not applicable ☐Yes ☐No
NEUROLOGICAL	
Level of Consciousness	☐ Person ☐ Time ☐Place ☐ Sedated ☐ Awake ☐Disoriented (Specify in Notes) ☐Confused ☐Incoherent ☐Lethargic ☐ Stuporous ☐Sedated ☐Unresponsive ☐Others(Specify)_____
Range of Motion	☐ Full ☐Limited ☐ Left Side Weakness ☐Right Side Weakness ☐Others (Specify)_____
Reflexes	☐ Cough ☐ Gag ☐ Corneal ☐ Babinski ☐ Areflexic
Grip	☐ Equal ☐ Bilateral Weakness ☐ Weak Upper Right ☐ Weak Upper Left☐ Unable to assess (Specify)_____
GLASGOW COMA SCALE	
Eye Opening	☐ 4=Spontaneous ☐ 3=To Speech ☐ 2=To Pain ☐ 1=None ☐ 1=Eyes closed by Swelling
Best Motor Response	☐ 6=Obeys Command ☐ 5=Localize Pain ☐ 4=Withdraws to Pain ☐ 3=Flexes to Pain ☐ 2=Extends to Pain ☐ 1=None
Best Verbal Response	☐ 5=Oriented ☐ 4=Confused ☐ 3=Inappropriate Words ☐ 2=Incomprehensible ☐1=None ☐1=With ETT/Tracheostomy
Total Score: _____	
PUPILLARY	
Pupillary Size (Right Eye)	☐ 1mm ☐ 2mm ☐ 3mm ☐ 4mm ☐ 5mm ☐ 6mm ☐ 7mm ☐ 8mm ☐Irregular
Pupillary Reaction (Right Eye)	☐ Brisk ☐ Sluggish ☐ No Reaction ☐ Eyes Closed by Swelling
Pupillary Size (Left Eye)	☐ 1mm ☐ 2mm ☐ 3mm ☐ 4mm ☐ 5mm ☐ 6mm ☐ 7mm ☐ 8mm ☐Irregular
Pupillary Reaction (Left Eye)	☐ Brisk ☐ Sluggish ☐ No Reaction ☐ Eyes Closed by Swelling
MOTOR FUNCTION	
Motor Function (Right Upper Extremity)	☐ Full Power ☐ Movement against gravity and some resistance ☐ Movement against gravity only ☐ Movement BUT NOT against Gravity ☐ Trace Movement ☐ No Movement
Motor Function (Left Upper Extremity)	☐ Full Power ☐ Movement against gravity and some resistance ☐ Movement Against Gravity only ☐ Movement BUT NOT against Gravity ☐ Trace Movement ☐ No Movement

Motor Function (Left Lower Extremity)	☐ Full Power ☐ Movement against gravity and some resistance ☐ Movement Against Gravity only ☐ Movement BUT NOT against Gravity ☐ Trace Movement ☐ No Movement
MUSCULOSKELETAL	
Presence of	☐Deformities ☐Swelling ☐Pain ☐Dressing ☐Not Applicable
Fracture	
Condition	☐Full ROM ☐Quick Cap Refill (less than 3 seconds) ☐Positive sensation ☐No ROM ☐Limited ROM ☐Poor cap refill (greater than 3 sec) ☐No sensation ☐Numb ☐Tingling ☐Presence of pain (note location)
Detailed description, if applicable	
PSYCHOSOCIAL	
Appearance	☐ Relaxed ☐ Restless ☐ Apprehensive ☐ Sedated ☐ Comatose ☐Obtunded ☐Others ,Specify_____
Behavior	☐ Cooperative ☐ Slumped Posture ☐ Rigid, Tense Posture ☐ Anxiety, Fear, Apprehension ☐ Depression, Sadness ☐ Anger, Hostility ☐Threatening ☐ Decreased Variability of Expression ☐ Bizarre Behavior ☐ Unresponsive ☐ Sedated
Communication	☐ Verbal ☐ Signs/Gestures ☐ Written ☐ Language Barrier ☐ Non-Responsive ☐ Sedated ☐Others ,Specify_____
CARDIOVASCULAR	
Telemetry Rhythm	☐ No Abnormality-NSR ☐ Not on Cardiac Monitor ☐Sinus Bradycardia ☐ Sinus Tachycardia ☐ w/ PVCs ☐ Sinus Arrhythmia ☐ Atrial Fibrillation (A-Fib) ☐ Atrial Flutter ☐ Junctional Rhythm ☐ Atrial Tachycardia (SVT) ☐ 1st Degree AV Block ☐2nd Degree AV Block ☐ 3rd Degree AV Block ☐ Bundle Branch Block ☐ Pacemaker ☐ Wandering Pacemaker ☐Ventricular Tachycardia (V-Tach) ☐ Ventricular Fibrillation (V-Fib) ☐ Other, Specify:_____
Heart Sounds	☐ Present ☐ Absent ☐ Split ☐ Gallop ☐ Murmur ☐ Distant ☐ Friction Rub ☐ Other,Specify:_____
Pacemaker	☐ None ☐ Temporary ☐ Permanent ☐ Epicardial ☐ External: Rate_____ mA_____ mV_____
Hemodynamic Monitoring System	☐ Arterial Line (A-line) ☐ Central Venous Pressure ☐ Pulmonary Artery Pressure ☐ Other, Specify:_____
Mucous Membranes & Nailbeds	☐ Pink ☐ Cyanotic ☐ Pale ☐ Other, Specify:_____
Jugular Veins	☐ Flat ☐ Distended
Capillary Refills	☐ RUE Normal ☐ LUE Normal ☐ RLE Normal ☐ LLE Normal ☐ RUE Abnormal ☐ LUE Abnormal ☐ RLE Abnormal

	☐ LLE Abnormal
Pulses	☐ +4 Bounding ☐ +3 Strong, Palpable ☐ +2 Weak, Palpable ☐ +1 Intermittent ☐ Absent ☐ Doppler ☐ Others, Specify:_____
Edema	☐ No Edema ☐ No Indentation ☐ 1+ Indent Gone Quick ☐ 2+ Indent 10-15 Seconds ☐ 3+ Indent 1-2 Minutes ☐ 4+ Indent >7 Minutes ☐ Other, Specify:_____
RESPIRATORY	
Breath Sounds	☐ Clear-Bilateral ☐ Equal ☐ Crackles Right ☐ Crackles Left ☐ Crackles Bilateral ☐ Wheezes Bilateral ☐ Wheezes Left ☐ Wheezes Right ☐ Rhonchi Bilateral ☐ Rhonchi Left ☐ Rhonchi Right ☐ Diminished Left ☐ Diminished Right ☐ Absent Right ☐ Absent Left ☐ Other, Specify:_____
Bilateral Lung Expansion	☐ Equal ☐ Unequal ☐ Spontaneous
Respiratory Pattern	☐ Regular/Even ☐ Irregular ☐ Dyspneic w/ Exertion ☐ Dyspneic ☐ Bradypnea ☐ Tachypnea ☐ Labored Inspiration ☐ Apnea ☐ Other, Indicate:_____
Cough	☐ No ☐ Yes, Non-Productive ☐ Yes, Productive
Respiratory Secretions	☐ None ☐ Suction Required ☐ Frothy ☐ Thin ☐ Thick ☐ Copious ☐ Green ☐ Yellow ☐ Bloody ☐ Pinkish ☐ Other, Specify:_____
O2 Use/Delivery System	☐ None-Room Air ☐ Nasal Cannula ☐ Simple Mask ☐ Venti-Mask ☐ Non-Rebreather Mask ☐ Bi-Pap ☐ C-Pap ☐ Ventilator ☐ Other, Specify:_____
O2 Delivery Device Settings: _____	
Chest Tube Location: _____	
Chest Tube Type: _____	
Chest Tube Drain Type: _____	
PARENTERAL THERAPY	
Primary Line: _____	
IV Drips: _____	
Indication for IV Devices:	☐ None/Not Indicated ☐ IV Fluid Administration ☐ IV Medication Administration –ie: antibiotics, vasopressors ☐ IV Electrolyte Administration ☐ Parenteral Nutrition ☐ Blood or Blood Product Transfusion ☐ Pressure Monitoring ☐ Other, Specify:_____
Catheter Type	☐ Not Applicable ☐ Peripheral Venous Catheter ☐ Pulmonary Artery Catheter ☐ Peripheral Arterial Catheter ☐ Peripherally Inserted Central Venous Catheter ☐ Totally Implantable [ie: Portacath] ☐ CVC Triple Lumen ☐ Permanent Tunneled CVC [e.g. Broviac, Hickman, Permacath] ☐ Non-Tunneled CVC [e.g. Mahurkar, Quinton]
IV sites	☐ Right Hand ☐ Left Hand ☐ Right Wrist ☐ Left Wrist ☐ Right Arm ☐ Left Arm ☐ Right Antecubital ☐ Left Antecubital ☐ Right Foot ☐ Left Foot ☐ Right Leg ☐ Left Leg ☐ Right Internal Jugular ☐ Left Internal Jugular ☐ Right Femoral ☐ Left Femoral ☐ Right Subclavian

	☐ Left Subclavian ☐ Not Applicable ☐ Other:_____
IV Heplock Sites	☐ Intact & Patent ☐ Redness ☐ Swelling ☐ Tenderness ☐ Infiltrated ☐ IV Burn ☐ Leaking ☐ Not Applicable ☐Other, Specify:_____
GASTROINTESTINAL	
Bowel Sounds	☐ Normal ☐ Absent ☐ Hyperactive ☐ Hypoactive ☐Other, Indicate_____
Abdomen	☐ Soft ☐ Firm ☐ Flat ☐ Round ☐ Distended ☐ Obese ☐ Hard ☐ Tender ☐ Non-Tender ☐Other, Specify_____
Bowel Movement	☐ Irregular Bowel Habits ☐ Incontinent ☐ Daily Bowel Movement ☐Frequent ☐Constipation ☐ BM every other day ☐ Laxative Use ☐ No BM
Stool	☐ Incontinent ☐ Liquid ☐ Soft ☐ Formed ☐ Ostomy ☐ Blood in Stool
Last Bowel Movement: _____	
BM Color: _____	
Gastrointestinal Tube Type:	☐ Not Applicable ☐ Naso-Gastric ☐ Oro-Gastric ☐ Gastrostomy ☐ Jejunostomy
Gastrointestinal Tube Location: _____	
Gastrointestinal Mode	☐ Not Applicable ☐ Clamped ☐ Gravity ☐ Low Continuous Suction ☐ Low Intermittent Suction
Gastrointestinal Residual: _____	
Diet Type: _____	
Tube Feeding Rate: _____	
Tube Feeding Type: _____	
Feeding	☐ Self ☐ Assistance ☐ Total Feed ☐Not Applicable ☐Others, Indicate_____
Tube Placement every 4 hours	☐ Yes ☐ No ☐ Not Applicable
GENITOURINARY	
Voiding	☐ Continent ☐ Urinal ☐ Bed Pan ☐ Bedside Commode ☐ Incontinent ☐ Stress Incontinence ☐ Foley ☐ Condom Catheter ☐ Dialysis ☐ Nephrostomy Tube ☐ Suprapubic Catheter ☐Others, Specify_____
How many days has the current foley catheter been in place: _____	

Has Patient/Family Education Assessment been completed on prevention of catheter-associated urinary tract infections?	☐ Yes ☐ No ☐ Not Applicable
Urine Appearance	☐ Clear ☐ Light yellow ☐ Amber ☐ Tea-Colored ☐ Blood in Urine ☐ Hazy ☐ Cloudy ☐ Sediment ☐ Milky ☐ Not Applicable
Foley Catheter Size: _____	
Indication/s for Indwelling Urinary Catheters	☐ Not Applicable ☐ Acute Urinary Retention or Bladder Outlet Obstruction ☐ Strict I&O for Critically Ill Patients, Physician Order ☐ Assist Healing-Open Sacral/Perineal Wounds Incontinent Patients ☐ Others: _____
24 Hour Urine Collection	☐ Yes [if Yes, Date and Time collection started: _____] ☐ No
SKIN	
Skin	☐ Warm ☐ Dry ☐ Intact ☐ Cool ☐ Diaphoretic ☐ Clammy ☐ Cracked ☐ Poor Turgor ☐ Rash [Specify below] ☐ Excoriation ☐ Decubitus [Specify below] ☐ Staples/Sutures ☐ Mottled
Color: _____	
Rash: _____	
Decubitus: _____	
Bruises/Abrasions: _____	
Incision	☐ Not Applicable ☐ Healing ☐ Intact ☐ No Redness ☐ No Drainage ☐ With drainage: Specify_____ ☐ Red, Puffy, Warm ☐ Well Approximated ☐ Obviously Infected
Describe Dressing Condition	☐ Not Applicable ☐ Clean and Dry ☐ No Drainage ☐ w/ Drainage , Specify_____
Describe Dressing Type	☐ Not Applicable ☐ 2x2 ☐ 4x4 ☐ Coverderm/Opsite ☐ Xeroform ☐ ABD ☐ Telfa ☐ Kerlix ☐ Ace Wrap
GYN	
Pad Count: _____	
Drainage/Discharge: _____	
HYGIENE	
Type of Bath/Shower taken	☐ Refused ☐ Deferred ☐ Sponge/ Bed Bath
Oral Care Completed	☐ Self ☐ Assisted ☐ Completed by Staff ☐ Denture Care Self
Perineal Care	☐ Yes, Specify: _____ ☐ No ☐ Not applicable
ACTIVITY	
Activity Level	☐ Bedrest ☐ Bedrest with BRP ☐ Dangle ☐ Up in Chair ☐ Ambulate with Assistance ☐ UP AD LIB ☐ Bedside Commode ☐ Sedated ☐ Others, Specify_____
Activity Tolerance	☐ Good ☐ Poor ☐ Fair ☐ Sedated ☐ Others, Specify_____
Turn q2 hours	☐ Yes ☐ No ☐ Not Applicable

TRANSMISSION BASED PRECAUTIONS	
Is the patient on any of the following Transmission Based Precautions?	☐ None ☐ Contact Precautions ☐ Special Contact Precautions ☐ Droplet Precautions ☐ Airborne Infection Isolation
If one of more are chosen above please complete Patient Education Details form.	
PAIN ASSESSMENT	
Presence of Pain	☐ Yes, Specify: _____ ☐ No
Location of Pain: _____	
Pain Level (Select)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Pain Assessment Tool Used:The use of an identified Pain Tool MUST be consistent throughout the patient's admission. It shall only change when the patient's condition has changed.	☐ Verbal Analog Scale ☐ FACES ☐ Multilingual Pain Assessment Tool ☐ Critical Care Pain Assessment Tool

BRADEN SCALE BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK (To be completed once a week)	
Ability to respond meaningfully to pressure-related discomfort	☐ COMPLETELY LIMITED: Unresponsive to painful stimuli= *1* ☐ VERY LIMITED: Responds only to painful stimuli-moan/restlessness= *2* ☐ SLIGHTLY LIMITED: Responsive but can't communicate discomfort= *3* ☐ NO IMPAIRMENT: Responsive, No Sensory deficit.= *4*
Degree to which skin is exposed to moisture	☐ CONSTANTLY MOIST: Skin is moist most of the time [sweat/urine]= *1* ☐ VERY MOIST: Often, but not always moist.= *2* ☐ OCCASIONALLY MOIST: Requires extra linen change once a day.= *3* ☐ RARELY MOIST: Skin is usually dry. Routine linen changes.= *4*
Degree of Physical Activity	☐ BEDFAST: Confined to bed.= *1* ☐ CHAIRFAST: Walking severely limited or non-existent.= *2* ☐ WALKS OCCASIONALLY: Only short distances. Mostly sitting= *3* ☐ WALKS FREQUENTLY: Walks outside or inside of room frequently. =*4*
Ability to change and control body position	☐ COMPLETELY IMMOBILE: No body/extremity position changes alone. =*1* ☐ VERY LIMITED: Slight, but insignificant changes in position.= *2* ☐ SLIGHTLY LIMITED: Independent changes in body/ extra positions.= *3* ☐ NO LIMITATION: Major, frequent changes without assistance.= *4*
Usual food intake pattern	☐ VERY POOR: Unable to, or rarely eats more than 1/3 of meal.= *1* ☐ PROBABLY INADEQUATE: Eats about ½ of meals.= *2* ☐ ADEQUATE: Eats over ½ of meals, on tube feedings, or TPN. =*3* ☐ EXCELLENT: Eats most of every meal; No supplements required.= *4*
Friction & Shear	☐ PROBLEM: Requires mod-to-max assistance and inability to lift.= *1*

	☐ POTENTIAL PROBLEM: Require minimum assistance, but skin still shears=*2* ☐ NO APPARENT PROBLEM: Moves independently in bed and chair.= *3*
Total Score:_____	
Is Score less than 12?	☐ Yes ☐ No ☐ Not Applicable

SAFETY	
Seizure Precaution:	☐ Yes ☐ No ☐ Not Applicable
Aspirations Precautions: HOB 15-30 degrees	☐ Yes ☐ No ☐ Not Applicable

RESTRAINT USE	
Is the Patient on Physical Restraints?	☐ Yes ☐ No ☐ Not Applicable

NOTE: Remember to complete the Behavior Activity Assessment as per policy. Every 2 hours for Medical - Surgical reasons and every 15 minutes for Behavioral Management reasons. The use of restraints has a limited time frame (restraint episode). If restraints are clinically justified to be continued, a Restraint Use Justification Assessment needs to be completed (for each episode) and accompanied by an MD order for restraints. The MD needs to perform an in-person evaluation before a restraint use order is renewed. Restraint duration for Medical-Surgical reasons is 24 hours. Restraint Duration for Behavioral Management is 4 hours (for ages 17 and older); 2 hours (for ages 9-17) and every 1 hour (for ages < 9 years old).

MORSE FALL SCALE ASSESSMENT TOOL ADULT	
History of Falls: (Options: Yes=25; No=0)	☐Yes = *25* ☐No = *0*
Secondary Diagnosis: (Two or more medical Diagnoses (Options: Yes=15; No=0)	☐Yes = *15* ☐No = *0*
Ambulatory Aid: (Options: Furniture=30; Crutches/Walker/Cane=15; None/Bedrest/Wheelchair/Nurse= 0)	☐Furniture = *0* ☐Crutches/Walker/Cane = *15* ☐None/Bedrest/Wheelchair = *0*
IV/ Saline Lock: (Options: Yes=20; No= 0)	☐Yes = *20* ☐No = *0*
Gait Transferring: (Options: Impaired= 20; Weak=10; Normal/Bedrest/Immobile=0)	☐Impaired = *20* ☐Weak = *10* ☐Normal/Bedrest/Immobile = *0*
Mental Status: (Options: Forgets Limitations=15; Oriented to own ability=0)	☐Forgets Limitations = *15* ☐Oriented to own ability = *0*
TOTAL SCORE: _____ ***(If score is greater than 45, complete the Fall Prevention Program Environmental Checklist)***	
Level of Risk Scores: ***If score is 0-24 = Low Risk for Fall and Standard Fall Precautions should be implemented.*** ***If score is 25-44 = Moderate Risk for Fall and Standard Fall Precautions PLUS additional preventative measures should be implemented.*** ***If score is greater than 45 = High Risk for Fall and Standard Fall Precautions PLUS additional high risk preventative measures should be implemented.*** ****Implement appropriate fall prevention strategies based on patient's risk level.****	
Is this patient at moderate risk for fall?	☐Yes ☐No

FURTHER INSTRUCTIONS	
Is this the first reported High Fall Risk for the patient?	☐Not Applicable ☐Yes ☐No
Does the patient need a Fall Risk Care Plan?	☐Yes ☐No
Please *INITIATE* The *Fall Risk Care Plan.*	
Was Fall Risk Precaution Taught?	☐Not Applicable ☐Yes ☐No
If No, Please complete the Patient Education Detail.	

FALL MEDICATIONS

Is this patient on any of these high alert medications? If yes please click box next to medication(s). If not, click box next to Not Applicable.

Benzodiazepines	Antipsychotics	Anticonvulsants	Tricyclic Antidepressants	Sedatives
☐Not Applicable ☐chlordiazepoxide ☐diazepam ☐ clonazepam ☐alprazolam ☐ lorazepam	☐Not Applicable ☐haloperidol ☐chlorpromazine ☐ quetiapine ☐ risperidone	☐Not Applicable ☐phenytoin ☐carbamazepine ☐gabapentine (if not renal dosed)	☐Not Applicable ☐amitriptyline ☐nortriptyline ☐doxepin	☐Not Applicable ☐phenobarbital ☐zolpidem

Is the patient on 1 or more of these HIGH ALERT medications above?	☐ Not Applicable ☐ Yes ☐ No

If yes, document strategies to Recommend to physician to reduce medication related falls by Choosing one of these boxes:

☐Not Applicable
☐lowering the dose
☐tapering off the medication
☐ discontinuing the agent
☐ reducing overall fall-risk-inducing drug (FRID) load

Is this patient on any of these CAUTION Medications? If yes please click box next to medication (s). If not, click box next to Not Applicable.

Opioids	Antihistamines	Muscle Relaxants
☐Not Applicable ☐fentanyl ☐meperidine ☐morphine ☐hydromorphone ☐oxycodone ☐hydrocodone ☐butorphanol ☐codeine ☐tramadol	☐Not Applicable ☐diphenhydramine ☐hydroxyzine ☐promethazine ☐ benztropine	☐Not Applicable ☐cyclobenzaprine ☐baclofen ☐methocarbamol
SSRI Antidepressants	**Cardiovascular Agents**	**Other**
☐Not Applicable ☐paroxetine ☐fluoxetine ☐sertraline	☐Not Applicable ☐clonidine ☐doxazosin ☐digoxin	☐Not Applicable ☐meotclopramide ☐trazodone ☐large volume magnesium infusion for L&D

Is the patient on 2 or more of these CAUTION medications above?	☐Not Applicable ☐Yes ☐No
If yes, Document strategies to Recommend to physician to Reduce medication related falls by clicking on boxes	☐Not Applicable ☐lowering the dose ☐tapering off the medication ☐discontinuing the agent ☐reducing overall fall-risk-inducing drug (FRID) load
PROBLEM LIST	
Please complete problems list:	
CLINICAL ALARMS	
Is the patient using any of the following high risk clinical Alarms (Ventilator, CPAP/BIPAP, Fetal Monitor, Infant Warmer, Patient Monitoring System, OB Trace Vue, Infant Ventilator, Oscillator Ventilator, Infusomat Infusion Pump, Nurse Call Light System, Bedside Monitor (Telemetry/Vital Signs), Perfusor Infusion Pump, Kidney Machine, Vital Signs Monitor)?	☐Yes ☐No ☐Not Applicable
Are the alarms set and audible?	☐Yes ☐No ☐Not Applicable
Was education provided on the high risk clinical alarm?	☐Yes ☐No ☐Not Applicable
If education was provided, please indicate for which High Risk Clinical Alarms	☐Not Applicable ☐Ventilator ☐CPAP/BIPAP ☐Fetal Monitor ☐Infant Warmer ☐Patient Monitoring System ☐OB Trace Vue ☐Infant Ventilator ☐Oscillator Ventilator ☐Infusomat Infusion Pump ☐Nurse Call Light System ☐Bedside Monitor (Telemetry/Vital Signs) ☐Perfusor Infusion Pump ☐Kidney Machine ☐Vital Signs Monitor
EQUIPMENT	
Equipment in Use	☐ ICU Bed ☐ ICU Central Monitor ☐ Oxygen ☐ Pulse OX ☐ Infusion Pump ☐Feeding Pump ☐ Suction ☐ Ventilator ☐ BIPAP ☐CPAP ☐ Sequential Compression Device ☐ Incentive Spirometer ☐ TED Hose ☐Lifepak Monitor ☐ Bedside Commode ☐ Trapeze & Frame ☐ Traction ☐Bariatric Bed ☐ Wheelchair ☐ Walker ☐ Crutches ☐ PCA Pump ☐Other, Specify:

ABUSE	
Are there any signs of abuse or neglect? (If YES, please document in notes)	☐ Yes ☐ No ☐ Unknown

ON-GOING SUICIDE ASSESSMENT	
*(**Level 1:** Has active thoughts, no plan, assessed as having significant risk for suicidal attempt or self-harm. **Level 2:** Has active thoughts, with plans, has presented with an existing suicidal attempt or attempted self-harm. **Any changes in the patient's level must have a detailed assessment documentation in Patient's Notes)***	
Suicide Risk Level: **LEVEL 1 (MINIMAL SUICIDE PRECAUTIONS)** **LEVEL 2 (STRICT SUICIDE PRECAUTIONS)**	☐ None- No current thoughts, no plans, no risk factors ☐ LEVEL 1- Has active thoughts, no plan, assessed as having significant risk for suicidal attempt or self-harm ☐ LEVEL 2 – Has active thoughts, with plans, has presented with an existing Suicidal attempt or attempted self-harm.

HOME MEDICATIONS	
Have home medications been reconciled this Admission?	☐ Yes ☐ No ☐ Not Applicable *If not, please explain why:-* _____

ALLERGIES	
Has allergy been been documented?	☐ Yes ☐ No ☐ Not Applicable

TRANSPORTATION AT DISCHARGE	
Patient/Family reminded of transportation arrangements at time of discharge	☐ Yes ☐ No ☐ Not Applicable

CHARGES	
Please select appropriate Response for charging purposes. Also, Do Not Forget to Process Charges in Order Entry.	Daily Air Mattress Charge: ☐ Yes ☐ No ☐ Not Applicable Daily Alternating Leg Pressure Pump Charge: ☐ Yes ☐ No ☐ Not Applicable Daily Traction/ Trapeze Equipment Use Charge: ☐ Yes ☐ No ☐ Not Applicable Daily Isolation Cart Charge: ☐ Yes ☐ No ☐ Not Applicable Daily Bilirubin Therapy Use Charge: ☐ Yes ☐ No ☐ Not Applicable

☐ Licensed Practical Nurse Name and Signature:_____

☐ Registered Nurse Name and Signature:_____

Date & Time: _____

ASSESSMENT Nursing NOTES: