MERCER COUNTY COMMUNITY COLLEGE
NURSING EDUCATION PROGRAM

NRS122 – NURSING ASSESSMENT FORM

SECTION 1 NURSING CARE CONSIDERATIONS

A. Information Source: ☐ Patient ☐ Other (relationship) _____

TB Screening: ☐ Reported done in past year, negative
☐ Not done, will order
☐ Positive

Immunization Record: ☐ Pt/Family reports up-to-date, records pending
☐ Not applicable, patients over age 20

B. Allergies: ☐ No ☐ Yes

☐ Medication _____

☐ Food _____

☐ Latex

☐ Other _____

C. Elimination Pattern:

Difficulties with bladder ☐ No ☐ Yes ☐ Incontinent Explain: _____

Difficulties with bowels ☐ No ☐ Yes ☐ Incontinent Explain: _____

Use of laxatives ☐ No ☐ Yes Explain: _____

D. GYN (If Applicable):
Last menses: _____

Problems: _____

E. Sleep Pattern:
Describe: _____

Use of sleep aids ☐ No ☐ Yes Type: _____

F. Pain Screen:

Are you experiencing any pain? ☐ Yes ☐ Acute ☐ Chronic No ☐

H. Addiction Assessment:

☐ Usage Denied/ Not Reported (skip to next section if negative)

Substance	Route	Age of 1st Use	Current Amount/Frequency	Duration of Current Use	Date/Amount of Most Recent Use

If smoking, information on quitting given: ☐ Yes ☐ No ☐ Refused Date: _____

SECTION 2 INITIAL ASSESSMENT: NURSING SECTION

J. Functional Screen:

Assess Patient's Ability To:	Independent	Requires Assistance	Requires Total Care	Has there been a significant change in status in last week or since this episode of illness began?
Transfer				____ Yes ____ No ____ Unknown
Ambulate				____ Yes ____ No ____ Unknown
Perform activities of daily living				____Yes ____ No ____Unknown

Assistive Devices: ____ None ____ Cane ____ Bedside Commode
____ Splint/braces ____ Wheelchair ____ Walker
____ Other (specify) _____

K. Fall Screen: (adult and adolescent specific)

1. Has history of one or more falls in the last 30 days (not sports related). ____ Yes ____No
2. Is the patient confused or disoriented? ____ Yes ____ No
3. Is the patient visually impaired affecting his/her daily activities of living? ____ Yes ____ No
4. Is the patient on medication causing postural hypotension/sedation? ____ Yes ____ No
5. Does the patient have an unstable gait or need help with balance? OR Does the patient need minimum assistance and/or walks with an aid? ____ Yes ____ No

L. Self Perception Concept:

What brings you into the hospital? _____

_____

_____

Tell me what you think about yourself. _____

_____

_____

What are you most concerned about now? _____

_____

_____

What do you want to work on while here? _____

_____

_____

Living arrangements: _____ Lives Alone _____ Lives With _____

_____

Describe your relationship with parents/guardian/family _____

_____

N. Appearance _____

_____

Additional Information _____

_____

O. Adolescent Specific

Any restrictions for gym ____ No ____ Yes Explain: _____

School: Grades_____ Attendance _____

Suspensions _____ Probation _____

SECTION III PRELIMINARY NURSING CARE PLAN (NCP)

Patient Strengths:	
	Supportive Family
	Motivated for treatment
	Able to process information
	History of responsiveness to treatment
	___Meds ___ ECT ___Psychotheraphy
	Ability to manage ADL's
	Ability to express feelings

Comments:

Problem/Needs:	
	Danger to self
	Assaultive
	Alteration in mood
	Impaired nutrition
	Substance abuse
	Chronic or acute pain
	Inability to manage ADL's as evidenced by _____
	Altered thought process
	Poor impulse control
	Disabling anxiety as evidenced by _____
	Self-injurious behavior

Comments

Interventions:	
	Provide safe patient environment
	Withdrawal assessment
	Provide limit setting
	Medication education
	Psychoeducation
	Pre/Post ECT care
	Intake and output
	Nutrition consulted ordered
	Pain evaluation
	Fall precautions

Comments

Discharge Planning Factors:	
	Patient education
	Family/Significant other education
	Medication education
	Home Health Agency
	Community resources

Comments