Regional Health Authority Central Manitoba Inc.
Office régional de la santé du Centre du Manitoba inc.

Admission History Record

Date: _____ **Time:** _____
Method of Arrival: _____
Language(s) Spoken: _____

Presenting Problem & Patient's Knowledge of Same:

Relevant Health History:

Communicable Disease Exposure: _____
Antibiotic resistant Organism (ARO) Screening
Hospitalized in past 6 months: ☐ Yes ☐ No
@ _____
Screening cultures on admission: ☐ Yes ☐ No

Facility transferred from: _____
Home Care: ☐ Yes ☐ No
Home Care Notified: ☐ Yes ☐ No
Hospital/Home Care Coordinator Communication completed and sent. ☐ Yes ☐ No
Home Care Coordinator: _____

Health Care Directive / Advance Care Plan: ☐ Yes ☐ No
Location: ☐ Home ☐ Other
Advance Care Plan: ____ C ____ M ____ R
(please attach form if patient has this)

Allergies: _____
_____
If yes, reaction: _____
Immunizations: Up to date: ☐ Yes ☐ No ☐ Unknown
Last Tetanus: _____

Medications	Dosage	Times Taken	Last Dose

Are you a smoker? ☐ Yes ☐ No
Have you smoked in the last 7 days? ☐ Yes ☐ No

DPIN: ☐ Accessed ☐ Not accessed ☐ Attached

Vital Signs:
BP _____ Pulse _____ Height _____ cm Weight _____ Kg
Temperature _____ Respiratory Rate _____ Oxygen Saturation _____

Regional Health Authority
Central Manitoba Inc.
Office régional de la santé
du Centre du Manitoba inc.

SYSTEMS ASSESSMENT

NEUROLOGICIAL:
- ☐ Dizziness
- ☐ Weakness
- ☐ Seizure
- ☐ Combative
- ☐ Paralysis/pares
- ☐ Pain
- ☐ Neck Stiffness
- ☐ Headache
- ☐ Speech
- ☐ See Neuro Record

Describe: _____

☐ No Difficulties

CIRCULATORY:
- ☐ Pain
- ☐ Cyanosis
- ☐ Diaphoresis
- ☐ Syncope
- ☐ Palpitations
- ☐ Edema
- ☐ Peripheral Pulses
- ☐ Pacemaker
- ☐ Monitor / rhythm
- ☐ Hypertension
- ☐ Past Blood Transfusion

Describe: _____

☐ No Difficulties

SKIN:
- ☐ Laceration
- ☐ Burn
- ☐ Rash
- ☐ Jaundice
- ☐ Bruising / petechia
- ☐ Skin & Pressure Sore Assessment

Describe: _____

☐ No Difficulties

RESPIRATORY:
- ☐ Dyspnea
- ☐ Cough
- ☐ Sputum
- ☐ Hemoptysis
- ☐ Cap refill
- ☐ Nail clubbing
- ☐ Smoker ☐ Non-smoker ☐ Quit
- ☐ Pain
- ☐ Chest sounds

RU _____ RL _____
LU _____ LL _____

Describe: _____

☐ No Difficulties

GASTROINTESTINAL:
- ☐ Last oral intake @: _____
- ☐ Indigestion
- ☐ Distension
- ☐ Bowel Sounds
- ☐ Bowel Movements (BM) q____ days
  Last BM: _____
- ☐ Nausea
- ☐ Vomiting: Frequency: _____
- ☐ Diarrhea: Frequency: _____
- ☐ Constipation
- ☐ Bleeding
- ☐ Hemorrhoids / fissures
- ☐ Pain
- ☐ Dehydration
- ☐ Recent weight change
- ☐ Change in appetite
- ☐ Special Diet
- ☐ Dentures ☐ U ☐ L
- ☐ Dysphagia

Describe: _____

☐ No Difficulties

ENDOCRINE:
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Thyroid

Describe: _____

☐ No Difficulties

URINARY:
- ☐ Dysuria
- ☐ Frequency
- ☐ Hematuria
- ☐ Retention
- ☐ Incontinence
- ☐ Indwelling catheter
  ☐ foley ☐ suprapubic
  Size: _____
  Last changed on: _____
- ☐ Multistix

Describe: _____

☐ No Difficulties

MUSCULOSKELETAL:
- ☐ Deformities
- ☐ Swelling
- ☐ Pain
- ☐ Distal circulation
- ☐ Decreased mobility
- ☐ Cast / splint
- ☐ Amputation
- ☐ Fall / Risk Assessment

Describe: _____

☐ No Difficulties

REPRODUCTIVE:
- ☐ Menstrual problems
- ☐ Menopausal
- ☐ Contraception
  Type: _____
- ☐ Pregnant: # of weeks _____
  EDC: _____
  FHR: _____
  ROM: _____
  G: _____ P: _____
  Rh: ☐ Pos ☐ Neg
- ☐ Pain
- ☐ Bleeding / discharge
  LNMP: _____

Describe: _____

☐ No Difficulties

Regional Health Authority
Central Manitoba Inc.

Office régional de la santé
du Centre du Manitoba inc.

SYSTEMS ASSESSMENT

EENT

EYES:

☐ Blurred Vision	☐ Rt	☐ Lt	
☐ Foreign Body	☐ Rt	☐ Lt	
☐ Contact Lenses	☐ Rt	☐ Lt	
☐ Glasses			
☐ Blind	☐ Rt	☐ Lt	

Visual Acuity: (Snellen test)

Rt: _____ Lt: _____

Describe: _____

☐ No Difficulties

EARS:

☐ Tinnitus	☐ Rt	☐ Lt
☐ Deafness	☐ Rt	☐ Lt
☐ Hearing Aids	☐ Rt	☐ Lt
☐ Pain	☐ Rt	☐ Lt

Describe: _____

☐ No Difficulties

NOSE:

☐ Epitaxis	☐ Rt	☐ Lt
☐ Pain	☐ Rt	☐ Lt
☐ Discharge	☐ Rt	☐ Lt

Describe: _____

☐ No Difficulties

THROAT:

☐ Pain

☐ Foreign body

Describe: _____

☐ No Difficulties

PSYCHOSOCIAL:

☐ Anxious
☐ Depressed
☐ Agitated
☐ Restless/pacing
☐ Combative
☐ Stressed
☐ Suicidal Risk
☐ Support Available

Describe: _____

☐ No Difficulties

FAMILY HISTORY

Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No

PEDIATRICS:

Diapers	☐ Yes	☐ No
Nocturia:	☐ Yes	☐ No
Parent rooming in	☐ Yes	☐ No
Does child get homesick:	☐ Yes	☐ No

Describe: _____

BIRTH RECORD:

Normal delivery ☐ Yes ☐ No

Premature ☐ Yes ☐ No # weeks ___ Weight ___ Length ___

Any illnesses since birth: _____

DIET:

Breast fed	☐ Yes	☐ No			
Bottle fed	☐ Yes	☐ No	Cup	☐ Yes	☐ No
Baby food	☐ Yes	☐ No	Solid food	☐ Yes	☐ No
Feed self	☐ Yes	☐ No			

Describe: _____

SLEEP:

Crib	☐ Yes	☐ No
Bed	☐ Yes	☐ No

Bedtime: _____

☐ No Difficulties

ORIENTATION: **RHA Patient Handbook** ☐ Yes ☐ No

Hand Hygiene Brochure ☐ Yes ☐ No

VALUABLES: ☐ Sent home ☐ Locked up ☐ None brought in

MEDICATIONS: ☐ Sent home ☐ Locked up ☐ None brought in

SPECIAL CONSIDERATIONS (LIVING AND SUPPORTS): _____

CONTACT INFORMATION

Name: _____

Relationship: _____ Phone Number: _____

Name: _____

Relationship: _____ Phone Number: _____

NURSE'S SIGNATURE:

Regional Health Authority
Central Manitoba Inc.
Office régional de la santé
du Centre du Manitoba inc.

DOUMENTATION GUIDELINES FOR ADMISSION HISTORY FORM

Data Required	Completion Instructions	Source
Addressograph information:	Patient demographics	
Date:	Current Date	
Time:	Current Time	
Method of arrival	Write how they came to unit. Wheelchair, walking, stretcher or carried	
Language(s) Spoken:	Specify Language of Choice	
Presenting Problems and Patient's knowledge of same:	Describe what brought patient to hospital. Current history of presenting problem. Document what patient states he knows about reason for admission	
Relevant Health History	Past medical history, such as CHF, MI, Surgery	
Communicable Disease exposure	Write name of disease and date of exposure	
Home Care	Check appropriate box	
Health Care Directive/ Advance Care Plan	Check appropriate box Identify category	
Allergies:	Identify allergies	
Immunizations:	Check appropriate box	
Medications:	Identify names of medication and dosages – May print DPIN and staple to History Form	
DPIN:	May Print DPIN and staple to History Form	
Vital Signs:	Document initial Vital Signs, Height and Weight	
System Assessment	Each area should be reviewed with patient and checks placed in appropriate boxes. Add comments in the describe area if needed. Check no difficulties box if appropriate.	
Nurse's signature	This is the nurse who completed the form.	

Canadian Emergency Department Information System (CEDIS) COMPLAINT LIST

CHECK ONE COMPLAINT ONLY

Substance Misuse
- ☐ Substance misuse / Intoxication
- ☐ Overdose ingestion
- ☐ Substance withdrawal

Mental Health & Psychosocial
- ☐ Depression / Suicidal / Deliberate self-harm
- ☐ Anxiety / Situational crisis
- ☐ Hallucinations / Delusions
- ☐ Insomnia
- ☐ Violent / Homicidal behavior
- ☐ Social problem
- ☐ Bizarre behavior
- ☐ Concern for patient's welfare
- ☐ Paediatric Disruptive behavior

Neurologic
- ☐ Altered level of consciousness
- ☐ Confusion
- ☐ Vertigo
- ☐ Headache
- ☐ Seizure
- ☐ Gait disturbance / Ataxia
- ☐ Head injury
- ☐ Tremor
- ☐ Extremity weakness / Symptoms of CVA
- ☐ Sensory loss /Parasthesias
- ☐ Floppy child

Opthalmology
- ☐ Chemical exposure, eye
- ☐ Foreign body, eye
- ☐ Visual disturbance
- ☐ Eye pain
- ☐ Red Eye, discharge
- ☐ Photophobia
- ☐ Diplopia
- ☐ Periobital swelling
- ☐ Eye trauma
- ☐ Re-Check eye

ENT - Nose
- ☐ Epistaxis
- ☐ Nasal congestion / Hay fever
- ☐ Foreign body, nose
- ☐ Upper Respiratory Tract Infection complaints
- ☐ Nasal trauma

ENT - Ears
- ☐ Earache
- ☐ Foreign body, ear
- ☐ Loss of hearing
- ☐ Tinnitus
- ☐ Discharge, ear
- ☐ Ear injury

ENT – Mouth, Throat, Neck
- ☐ Dental /Gum problems
- ☐ Facial trauma
- ☐ Sore throat
- ☐ Neck swelling / Pain
- ☐ Neck trauma
- ☐ Difficulty swallowing / Dysphagia
- ☐ Facial pain (non-traumatic / non-dental)

Cardiovascular
- ☐ Cardiac arrest (non-traumatic)
- ☐ Cardiac arrest (traumatic)
- ☐ Chest pain (cardiac features)
- ☐ Chest pain (non-cardiac features)
- ☐ Palpitations / Irregular heart beat
- ☐ Hypertension
- ☐ General weakness
- ☐ Syncope / Pre-syncope
- ☐ Edema, generalized
- ☐ Bilateral leg swelling / Edema
- ☐ Cool pulseless limb
- ☐ Unliateral reddened hot limb

Respiratory
- ☐ Shortness of breath
- ☐ Respiratory arrest
- ☐ Cough / Congestion
- ☐ Hyperventilation
- ☐ Hemoptysis
- ☐ Respiratory foreign body
- ☐ Allergic reaction
- ☐ Stridor
- ☐ Wheezing – no other complaints
- ☐ Apneic spells infants

Gastrointestinal
- ☐ Abdominal pain
- ☐ Anorexia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Foreign body rectum
- ☐ Groin pain / Mass
- ☐ Vomiting and / or nausea
- ☐ Rectal / Perineal pain
- ☐ Vomiting blood
- ☐ Blood in stool //Melena
- ☐ Jaundice
- ☐ Hiccoughs
- ☐ Abdominal mass / Distention
- ☐ Anal / Rectal trauma
- ☐ Oral / Esophageal foreign body
- ☐ Feeding difficulties in newborn
- ☐ Neonatal jaundice

Environmental
- ☐ Frostbite / Cold injury
- ☐ Noxious inhalation
- ☐ Electrical injury
- ☐ Chemical exposure
- ☐ Hypothermia
- ☐ Near drowning

Trauma
- ☐ Major trauma - penetrating
- ☐ Major trauma - blunt
- ☐ Isolated chest trauma-penetrating
- ☐ Isolated chest trauma - blunt
- ☐ Isolated abdominal Trauma – penetrating
- ☐ Isolated abdominal Trauma - blunt

Skin
- ☐ Bite
- ☐ Sting
- ☐ Abrasion
- ☐ Laceration / Puncture
- ☐ Burn
- ☐ Blood and body fluid exposure
- ☐ Pruritus
- ☐ Rash
- ☐ Localized swelling / Redness
- ☐ Wound check
- ☐ Other skin conditions
- ☐ Lumps, bumps, calluses
- ☐ Redness / Tenderness, breast
- ☐ Rule out infestation
- ☐ Cyanosis
- ☐ Spontaneous bruising
- ☐ Foreign body, skin

General & Minor
- ☐ Exposure to Communicable disease
- ☐ Fever
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Direct referral for consultation
- ☐ Dressing change
- ☐ Imaging tests
- ☐ Medical device problem
- ☐ Prescription / Medication request
- ☐ Ring removal
- ☐ Abnormal lab values
- ☐ Pallor / Anemia
- ☐ Post-Operative complications
- ☐ Inconsolable crying in infants
- ☐ Congenital problem in children
- ☐ Minor complaints - not otherwise specified
- ☐ Cast check
- ☐ Removal staples / Sutures

Genitourinary
- ☐ Flank pain
- ☐ Hematuria
- ☐ Genital discharge / Lesion
- ☐ Penile swelling
- ☐ Scrotal pain and/or swelling
- ☐ Urinary retention
- ☐ Urinary tract infection complaints
- ☐ Oliguria
- ☐ Polyuria
- ☐ Genital trauma

Orthopedic
- ☐ Back pain
- ☐ Traumatic back / Spine injury
- ☐ Amputation
- ☐ Upper extremity pain
- ☐ Lower extremity pain
- ☐ Upper extremity injury
- ☐ Lower extremity injury
- ☐ Joint(s) swelling
- ☐ Paediatric gait Disorder / Painful walk

Ob – Gyn
- ☐ Menstrual problems
- ☐ Foreign body, vagina
- ☐ Vaginal discharge
- ☐ Sexual assault
- ☐ Vaginal bleeding
- ☐ Labial swelling
- ☐ Pregnancy issues, <20 weeks
- ☐ Pregnancy issues, >20 weeks
- ☐ Vaginal pain / itch

NURSE SIGNATURE

DATE: _____