



**OB ADMIT**

Includes History, Education, Needs, Discharge planning, Physical Assessment, & Admit Notes.

(Part 2 - See triage E-Form)

form version 1.0

<b>PATIENT</b>	TEST PATIENT	<b>ACCT#</b> CPSI64	<b>MR#</b> 999999	<b>DOB</b> 02/02/1920	<b>AGE</b> 89
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**Admit Date** 07/15/09 **Admit Time** 1600 **Information Obtained From:** Patient

**Orientation to Room:**  Reviewed All with:  Patient  Pt. & Family/Other  Family/Other

Introduced to assigned team  Call Light / Siderails / Bed controls  Telephone & phone number  TV / Radio Control

Bathroom  Activity allowed  Visiting Hours / Locked unit / Leaving unit  Mealtimes  Infant Security  Photo/Video use

Correct ID Band on / Allergy Star  Fall Precautions  Precautions  Pt. Info packet given by registration

**Valuables**  None

Dentures  Eye Glasses  Contacts  Hearing Aid(s)  Prosthetic/Ambulatory aids

Wallet/Purse  Clothing  Car Seat  Radio/Ipod  Cell Phone  Jewelry  Infant care items

Describe Suitcase maternal and child clothes, camera

Sent Home

At bedside, patient informed of policy  Items sent to safe / tag in chart **Comment**

**Current Living Situation:**

Independent  Dependent  Alone  Group Home  Lives with relative  Lives with parent  Significant other

Comment:

**Present in Patients living environment:**

Running water  Electricity  Stairs  Cooking facilities  Refridgeration  Heating  Cooling  Telephone

Transportation  Infant care supplies  Laundry facilities  Adult assistance available  Comment

**Advance Directives**  Does not wish to discuss at this time

Pt interested in Advance Directive  Forms Provided  Living Will pamphlet given to patient  Advanced Directive copy on chart

Has Living Will, family/SO instructed to bring to hospital  Retrieval needed Location

**Organ Donor:**  Yes  No  Anatomical Organ Program Member

**Medical Power of Attorney**  Same as Emergency Contact Name Phone #

Pt. requested accomodations:  Family

aware of all of pt's wishes.

**Release of Information** Who may we release info to? Anyone Phone Number:

**Transfusion** Have you ever had a blood transfusion?  No  Yes

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**Surgical/Invasive Procedure History**

**History of anesthesia problems** None

**Patient**  **Family**

Patient Reaction	Family Member	Comment
<input checked="" type="checkbox"/> Difficult airway		Said I have no chin
<input type="checkbox"/> High fever in the Operating room		
<input type="checkbox"/> Malignant Hyperthermia		
<input type="checkbox"/> Stay on the vent longer than expected		
<input type="checkbox"/> Severe post op N / V		
<input type="checkbox"/> Headache with regional anesthesia		
<input type="checkbox"/> Other		
<input type="checkbox"/> High fever in the Operating room		
<input type="checkbox"/> Malignant Hyperthermia		
<input checked="" type="checkbox"/> Stay on the vent longer than expected	Mother	
<input type="checkbox"/> Other		



## IMMUNIZATIONS

Document ALL immunization dates through demographic icon in flowchart

Vaccination	Assessment
<b>Rubella</b> <input type="checkbox"/> Immune <input checked="" type="checkbox"/> Will receive Rubella Vaccine postpartum <input type="checkbox"/> Refuses Rubella vaccine	
<b>Rhogam</b> <input type="checkbox"/> Received prenatal <input checked="" type="checkbox"/> Needs Rhogam pending results <input type="checkbox"/> Not Indicated	
<b>Pneumococcus</b> <input type="checkbox"/> Already received Pneumonia vaccine <input checked="" type="checkbox"/> Needs Pneumovax postpartum <input type="checkbox"/> Refuses pneumonia vaccine	
<b>Influenza (Oct - Mar)</b> <input type="checkbox"/> Had Influenza vaccine this season <input checked="" type="checkbox"/> Need Influenza vaccine postpartum <input type="checkbox"/> Refuses influenza vaccine	
<b>Tetanus / Diphtheria (&gt; 2yrs needs Pertussis in Tdap)</b> <input type="checkbox"/> Had Tdap <input type="checkbox"/> Had Td less than 2 yrs ago (not eligible for Tdap) <input checked="" type="checkbox"/> Had Td > 2yrs ago and needs Tdap postpartum <input type="checkbox"/> Refuses Tdap	

<b>Lab Results:</b>	Blood Type & Rh <input type="radio"/> Negative	Rubella Titer Non-Immune	Serology <input type="radio"/> Neg
	HBsAG <input type="radio"/> Neg	HIV Results on File <input type="radio"/> GBS <input type="radio"/> Pos	Other <input type="radio"/>

### Plans for Hospital Stay

Primary support person for Labor & Delivery:	Billy Bob
Other person in Labor & Delivery:	Mother - Gertrude
Personal Requests:	Ball
Anesthesia plans:	<input type="checkbox"/> None discussed <input type="checkbox"/> Desires none if possible <input type="checkbox"/> Local <input checked="" type="checkbox"/> Epidural Other As soon as possible
Adoption <input type="radio"/> Yes <input checked="" type="radio"/> No	Contact with Infant? <input type="radio"/> Yes <input type="radio"/> No
Adoption Agency Contact:	
Feeding Preference	<input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input checked="" type="checkbox"/> Both <input checked="" type="checkbox"/> Using a pacifier <input checked="" type="checkbox"/> Educated on pacifier use with breast feeding and AAP recommendations
For BTL - is signed authorization on chart?	<input type="radio"/> Yes <input checked="" type="radio"/> No, Physician notified <input type="radio"/> Not indicated
Circumcision planned?	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Unsure, education material given

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### Discharge Planning

Current utilization of community resources	<input checked="" type="checkbox"/> W.I.C. <input type="checkbox"/> Home Health Agency <input type="checkbox"/> P.A.T.T <input type="checkbox"/> Social / Case worker <input type="checkbox"/> DHS
Intended destination post discharge	<input checked="" type="checkbox"/> Home <input type="checkbox"/> Relative's home <input type="checkbox"/> Friend's home <input type="checkbox"/> Boarding home Other <input type="checkbox"/>
Referrals - Anticipated	<input type="checkbox"/> None

Referral	Status	Notes
Will send referral	<input checked="" type="checkbox"/>	
W.I.C.	<input type="checkbox"/>	
Public Health Nurse	<input checked="" type="checkbox"/>	Home visit High risk PPD
Lactation Consultant	<input checked="" type="checkbox"/>	
Women Care	<input type="checkbox"/>	
Social Worker	<input type="checkbox"/>	
Dietician	<input checked="" type="checkbox"/>	Excessive wt gain in pregnancy and breastfeeding
Mental Health	<input checked="" type="checkbox"/>	Past hx depression & PPD depression
Dept. of Human Services (DHS)	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

### Learning needs/Teaching

Learning need	Addressed by using (H) andout, (L)ecture, (V)ideo	Expressed understanding	Needs reinforcement	Additional
<input type="checkbox"/> Pt. Bedside Handbook Explained	<input checked="" type="checkbox"/> H <input checked="" type="checkbox"/> L	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Pain management/Pain scale	<input checked="" type="checkbox"/> L In handbook	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

