DELRAY
Medical Center

WOUND TREATMENT OF DELRAY MEDICAL CENTER

NURSING ASSESSMENT

DEL2128

Information obtained: ❑ Over the phone ❑ In person ❑ Records (specify)________

Informant: ❑ Patient ❑ Spouse ❑ Other (specify)________

VITAL SIGNS			
T:________	P:________	R:________	BP:________
Height:________		Weight:________	

MEDICATION	DOSAGE	MEDICATION	DOSAGE

DOES PATIENT SHOW ANY SIGNS OF SUSPECTED ABUSE OR NEGLECT? ❑ Yes ❑ No

If YES, was Physician Notified? ❑ Yes ❑ No
If YES, was Social Services Notified? ❑ Yes ❑ No

Comments:________

BEHAVIOR: ❑ Calm ❑ Angry ❑ Cooperative ❑ Uncooperative

IMMUNIZATIONS: (<15 years of age, assess) (>15 years of age, n/a)

❑ 2 Mos DTP, OPV, Hib, Hep B
❑ 4 Mos DTP, OPV, Hib, Hep B
❑ 6 Mos DTP, OPB, Hib, Hep B
❑ 12 Mos MMR>Hib Booster
❑ 15 Mos DTP/DTP
❑ 4-6 Yrs DTP Booster, OPV Booster, MMR 2nd Dose
❑ 14-16 Yrs Td Booster & q 10 yrs

RN Signature ________ Date/Time Information Obtained ________

DEL2128 IMMS# 000000 Rev. 10/2009 pw

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PATIENT HISTORY

NEUROLOGICAL:	❑ No stated problem ❑ Memory loss ❑ Dementia ❑ Stroke ❑ Seizures ❑ Headaches ❑ Dizziness ❑ Neuropathy Comments______
SENSORY:	❑ No stated problem ❑ Glasses ❑ Cataracts ❑ Vision impaired ❑ Glaucoma ❑ Hearing impaired ❑ Deaf Comments ______
CARDIOVASCULAR:	❑ No stated problem ❑ Hx of MI ❑ CABG ❑ AVR/MVR ❑ Stent ❑ Angioplasty ❑ Pacemaker ❑ High Blood Pressure ❑ Low Blood Pressure ❑ Irregular Beats Comments______
PULMONARY:	❑ No stated problem ❑ Pneumonia ❑ Emphysema ❑ Asthma ❑ COPD ❑ Shortness of Breath ❑ Bronchitis Comments______
GASTROINTESTINAL:	❑ No stated problem ❑ Nausea/Vomiting ❑ Bleeding ❑ Ulcers ❑ Hemorrhoids ❑ Laxatives ❑ Indigestion ❑ Hiatal Hernia ❑ Diarrhea ❑ Incontinence ❑ Constipation ❑ Obstruction ❑ Ostomy Comments______
RENAL:	❑ No stated problem ❑ Prostate ❑ Frequency ❑ Burning ❑ Urgency ❑ Incontinence ❑ Catheter & Type ______ ❑ Dyalisis and type ______ Shunt location______ Comments ______
HEPATIC:	❑ No stated problem ❑ Liver disease ❑ Anemia ❑ Bleeding problems Comments ______
ENDOCRINE:	❑ No stated problem ❑ Hyperthyroid ❑ Hypothyroid ❑ Hypoglycemia ❑ NIDDM, How many years? ______ ❑ IDDM, How many years? ______ ❑ Average blood sugar Comments______
MUSCULOSKELETAL:	❑ No stated problem ❑ Pain/Discomfort ❑ Gout ❑ Arthritis ❑ Difficulty Walking ❑ History of falls ❑ Prosthesis-Describe ❑ Fractures-Describe Comments ______
REPRODUCTIVE:	❑ No stated problem ❑ Menopause ❑ Discharge or Bleeding ❑ Pregnancy ❑ Implants-Type Comments ______
INFECTIOUS DISEASE:	❑ No stated problem ❑ TB ❑ Hepatitis ❑ Immunosuppressed ❑ Other Comments______
PHYSCHOLOGICAL:	❑ No stated problem ❑ Anxiety ❑ Depression ❑ Forgetful ❑ Phobia ❑ History of chemical dependency Comments______
ONCOLOGY:	❑ No stated problem ❑ Cancer type ______
INTEGUMENTARY:	❑ No stated problem ❑ Rashes ❑ Dryness ❑ Itching ❑ Bruises ❑ Lumps ❑ Draining wounds ❑ Sores Comments______

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ALLERGIES	REACTION

HOSPITALIZATION/SURGERIES	DATE

NUTRITION SCREEN

Describe your appetite: ❑ Good ❑ Fair ❑ Poor ❑ Indigestion ❑ Nausea ❑ Vomiting ❑ Tube Feeding

Special Diet: ❑ Yes ❑ No Type:

Supplements: ❑ Yes ❑ No Type:

In the past 3 months:
Changes in appetite? ❑ Yes ❑ No
Unusual weight gain? ❑ Yes ❑ No Reason?________
Unusual weight loss? ❑ Yes ❑ No Reason?________
MEDICAL DOCTOR AWARE? ❑ Yes ❑ No (If no, notify patient's MD-document in chart)

FUNCTIONAL SCREEN

Eating	I A D	Dressing	I A D	Oral Hygiene	I A D
Toileting	I A D	Bathing	I A D	Mobility	I A D

❑ Moves all Ext ❑ Up with assist ❑ Bedridden ❑ W/C Bound ❑ ROM limited

Have you recently experienced a decrease in: ❑ Strength ❑ Endurance ❑ Ambulation ❑ Mobility
MEDICAL DOCTOR AWARE? ❑ Yes ❑ No (If no, notify patient's MD-document in chart)

Previous Blood Transfusion? ❑ Yes ❑ No Transfusion Reaction ❑ Yes ❑ No
Autologous Blood Donated? ❑ Yes ❑ No

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Where do you currently live?
❑ Home/alone
❑ Home/with family
❑ Nursing Home (specify)
❑ Other

Who is your primary caregiver/support person?

Do you have any concerns about your current health status?

Do you use medical equipment at home? ❑ Yes ❑ No
(check all that apply)
❑ Oxygen ❑ Nebulizer ❑ Brace ❑ Cane ❑ Walker ❑ Wheelchair
❑ Hospital Bed ❑ BSC ❑ Other

Do you have financial concerns regarding your hospitalization? ❑ Yes ❑ No

Do you smoke? ❑ Yes If yes, how many years?__________ Packs per day? ________
❑ Quit If quit, how many years?__________
❑ Never

Do you drink alcohol? ❑ Yes If yes, frequency/amount: __________
❑ No

Who referred you to the Wound Treatment Center?

Would you like a doctor to receive a copy of your progess note?
Whom?______________________________ Phone#______________________
Whom?______________________________ Phone#______________________
Whom?______________________________ Phone#______________________

Language spoken: ❑ English ❑ Other ___________ Need for Interpreter? ❑ Yes ❑ No

Reason for admission in patient's own words:

Occupation

Do you have any special Religious or Cultural requests during your visits at the Wound Treatment Center? ❑ Yes ❑ No
If yes, EXPLAIN:

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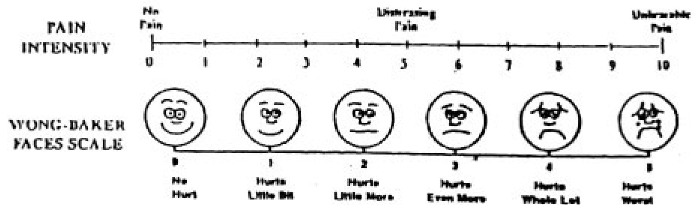
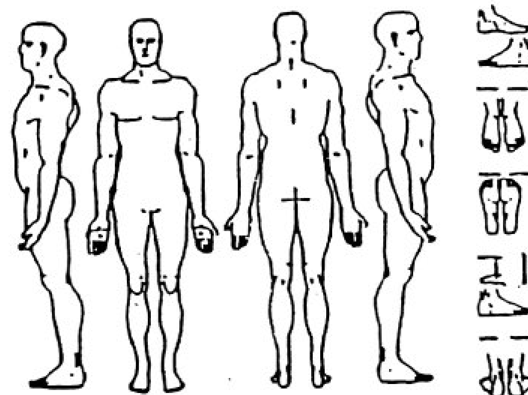
Are you experiencing pain now? ❑ Yes ❑ No
If patient answers yes, initiate pain assessment form



Location of pain____________________
Where is it? ____________________

Observation of pain site:____________________
How does it look? ____________________

Present management of pain____________________



Quality (Description)	❑ Prick ❑ Ache ❑ Burn ❑ Throb ❑ Sharp ❑ Dull ❑ Stabbing ❑ Other____________
Onset	❑ Sudden ❑ Gradual ❑ Other
Symptoms of Pain ❑ Unable to Sleep	❑ Nausea ❑ Headache ❑ Dizziness ❑ Weakness ❑ Drowsiness ❑ Perspiration ❑ Loss of appetite ❑ Other
Duration	❑ Continuous ❑ Intermittent, how long does it last? ❑ Other____________
Aggravating Factors	❑ Rest ❑ Activity ❑ Heat ❑ Cold ❑ Meds ❑ Other____________
Effects of pain on ADL's	❑ Able to perform ❑ Unable to perform ❑ Needs complete assist ❑ Needs partial assist ❑ Other____________
Cultural/Religious Influences on pain management	❑ None ❑ Cultural Needs____________ ❑ Religious Needs____________ ❑ Other____________
Patient's goals for pain management	❑ Complete relief ❑ Partial relief ❑ Perform ADL's ❑ Other____________

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	Location	Cause	Duration	Has wound ever been completely healed?	Prior Dressings	Prior Tests	Wound Pain Present** (Yes or No)
Wound #1							
Wound #2							
Wound #3							
Wound #4							
Wound #5							
Wound #6							

**See initial Pain Assessment Form

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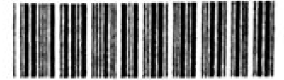
Tenet South Florida



Fax

TO: Name____________________ Number of Pages to follow: __________

Company____________________ If you have any trouble in the receipt

Telephone#____________________ of this transmission, please call:

Fax#____________________ (561) 495-3412

CC: Name____________________ Name____________________

Tel#____________________ Tel#____________________

Fax#____________________ Fax#____________________

From Wound Treatment Center of Delray Medical Center
5130 Linton Blvd., Suite D-3
Delray Beach, FL 33484
Tel 561-495-3412 • Fax 561-495-3388

Messages/Comments

The following is a copy of the Progress Note on patient____________________ who was seen at the Wound Treatment Center of Delray Medical Center for follow-up wound care. Please contact us if you have any questions at (561) 495-3412.

Thank you!

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