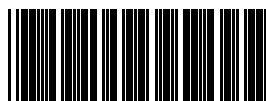


INITIAL ASSESSMENT NURSING CARE



DT9109

1- PRELIMINARY DATA

ARRIVAL	Year	Month	Day	Time	on foot <input type="checkbox"/>	Other :
	alone <input type="checkbox"/> accompanied by :					
LANGUAGE	spoken		understood			
RELIGION	Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Other :					
PERSONS TO BE CONTACTED	Name			Relationship		at work res. ()
	Name			Relationship		Tel. () ()
PERSONS TO BE CONTACTED	Name			Relationship		at work res. ()
	Name			Relationship		Tel. () ()

Reason for hospitalization
(according to user)

General aspect (behaviour and appearance, weight variation, etc.)

Pulse	BP	T (°C)	Resp.	Height (m)	Weight (kg)	Right handed <input type="checkbox"/>	Left handed <input type="checkbox"/>
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2- HEALTH PROBLEMS

PARAMETERS	ALTERATIONS NOTED	SPECIFICATIONS (therapeutic material used)
Respiration (tract, characteristics, associated problems...)	no <input type="checkbox"/> yes <input type="checkbox"/>	
Digestion (alimentary tract, mastication, deglutition, appetite...)	no <input type="checkbox"/> yes <input type="checkbox"/>	
Elimination (tract, characteristics, control...)	no <input type="checkbox"/> yes <input type="checkbox"/>	
Skin/Appendages (integrity, appearance, temperature...)	no <input type="checkbox"/> yes <input type="checkbox"/>	
Mobility (integrity, endurance, comfort...)	no <input type="checkbox"/> yes <input type="checkbox"/>	
Cognition/Perception (senses, language, writing, memory, concentration, orientation, judgment...)	no <input type="checkbox"/> yes <input type="checkbox"/>	
Sleep (quality, duration...)	no <input type="checkbox"/> yes <input type="checkbox"/>	
Sexuality/Reproduction (integrity...)	no <input type="checkbox"/> yes <input type="checkbox"/>	
Other health problems and prehospitalization treatment: no <input type="checkbox"/> yes <input type="checkbox"/> specify :		Known allergy, to drugs, other: no <input type="checkbox"/> yes <input type="checkbox"/> specify nature and reactions :

Special diet: no yes specify:

MEDICATION (taken before hospitalization, prescribed or not)

Name	Dosage	Usage known	Name	Dosage	Usage known

User's name	File no.
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3- LIFESTYLE

CATEGORIES	SPECIFICATIONS (nature, frequency, changes, requirements)
Nutrition (food groups, fats, sugar...)	
Physical activity (sports, exercise...)	
Hygiene (skin, hair, nails, teeth...)	
Tobacco/alcohol/drugs	
Work/recreation/other activities	
Spirituality (values, beliefs, practice...)	

4- ENVIRONMENT

Social support network

Work environment (stressor agents: psychological/physical/chemical...)

Living environment (favourable, unfavourable)

Significant incidents (family conflicts, economic difficulties, mourning, job loss, breakup...)

5- ADJUSTMENT TO STRESS

Previous hospitalization: no yes (reaction, expectations, repercussions...)

Hospitalization and current state of health: (reaction, expectations, repercussions...)

Means used to reduce stress

6- ANALYSIS AND SYNOPSIS

Nurse's signature

Year	Month	Day
_ _	_	_
Date		