

HEALTH ASSESSMENT

Health history given by: Patient ____ Other: (state relationship)_____

Remember to attach the front “work sheet” to this and incorporate DSM-IV criteria, symptoms currently seeing and medications. Also attach the lab and medication pages.

3. A UNIVERSAL REQUISITE: PROMOTION OF NORMALCY

1. Coping/ Stress:

The assessment data here describes the general coping pattern and the effectiveness of the coping mechanisms. Elicit and document information about your patient’s perception of and reaction to the current stressors or problems as well as any major losses that may have been experienced within the last year. Questions regarding support systems and available resources should be asked and noted.

Determine and document if and how the patient’s present condition is perceived as a stressor and what coping strategies are being utilized.

2. Self Perception/ Self Concept:

The assessment data here describes the patient’s attitudes and beliefs about personal abilities, identity, self worth and body image. Elicit and document information about your patient’s emotions and feelings as they relate to his/her ability to interact with others as well as how the current health condition affects self-attitude.

If the patient’s present condition has produced negative feelings towards self, determine and document how these feelings effect the patient’s ability to accept the current health problem and the changes that may occur.

3. Value-beliefs

The assessment data here describes the values, goals and beliefs that influence your patient’s choices and lifestyle. Elicit and document information about your patient’s life’s beliefs and values, including spiritual, religious, cultural and philosophical beliefs.

Questions regarding beliefs about health and illness should be asked and noted. Determine if your plan of care conflicts with the patient’s values and beliefs.

HEALTH PROMOTION/ DISCHARGE PLANNING NEEDS:

If a problem or potential problem does exist, you must determine teaching/ learning needs of the client. If the problem warrants collaboration with other departments to meet the client’s needs after discharge.

NURSING DIAGNOSIS:

From the data you have obtained, you must determine and state if an actual or potential health problem exists and if so, formulate a nursing diagnosis.

3. B UNIVERSAL REQUISITE: AIR**ASSESSMENT DATA:**

The assessment data should include all information related to the client's oxygenation. Some examples of information to include are: lung sounds, use of oxygen, cough, dyspnea, O2 saturation, pulses and capillary refill.

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3.C UNIVERSAL REQUISITE: WATER**ASSESSMENT DATA:**

Assessment data should include evaluations of client's skin turgor, mucous membranes, intake and output, presence of edema, intravenous, oral and gastric tube intake or output, as well as significant diagnostic tests.

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3.D UNIVERSAL REQUISITE: FOOD**ASSESSMENT DATA:**

Assessment data should describe client's food intake. Elicit and document information about your client's process of ingestion (chewing, swallowing), digestion, absorption, transport and metabolism. How is the client's nutritional/caloric intake? Is the client able to feed him/her self? Has there been weight gain, weight loss (BMI) and/or change in energy level. Are there symptoms of nausea, gas, or pain, determine and document how

these symptoms being addressed. Elicit and document information about your client's knowledge of nutrition and how nutrition relates to their well-being.

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3.E. UNIVERSAL REQUISITE: ELIMINATION

ASSESSMENT DATA:

1. Bowel/emesis

Include information related to routine bowel habits, aides for constipation, understanding of proper food and fluid intake as well as abdominal assessment.

2. Urination

Include information related to urination, pain with urination, frequency, dribbling, color, amount and aroma of excretions and secretions. If collection devices such as urinary catheter is being used, assess and document your client's understanding and knowledge of why the device is being utilized and how to care for it.

3. Skin Integrity

Assess and document the condition, and color of your client's skin, noting any abnormalities such as discolorations, presence of lesions rashes, and breaks in integrity.

4. Wound Assessment

Utilize REEDA method to evaluate wound. Note drainage, amount, odor, surrounding skin and wound bed.

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3. F UNIVERSAL REQUISITE ACTIVITY/ REST/ SLEEP**ASSESSMENT DATA:**

The assessment data here describes the patient's usual pattern of exercise and activity including the ability to perform activities of daily living and to participate in leisure and recreational activities. Elicit and document information about the patient's desire, choice and actual involvement in self-care, work, exercise and leisure activities.

Determine and document if and how the patient's present condition has interfered with the ability to perform these activities and how activity/mobility needs are being met. Has the patient's present condition produced symptoms such as chest pain, dyspnea, claudication, fatigue, weakness or musculoskeletal pain? Determine and document how these symptoms are being addressed.

If assistive devices are being used, assess and document your patient's knowledge of why the device is being used and how to safely use it.

The assessment data here describes the patient's usual pattern of sleep, rest and relaxation. Elicit and document information about the patient's perception of the effectiveness of his/her sleep and relaxation methods as well as any routines or activities used to promote sleep.

Determine and document if and how the patient's present condition has interfered with the ability to sleep and/or relax.

If the patient's present condition has produced symptoms that cause an inability to sleep or if the environment interferes with the ability to sleep, determine and document how these symptoms are being addressed.

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3.G UNIVERSAL REQUISITE: SOLITUDE/ ISOLATION**ASSESSMENT DATA:**

The assessment data here describes the roles and relationships of the patient and examines the patient's self evaluation of his/her performance related to these roles. Elicit and document information about your patient's role and responsibility at work, in the family or in the community (social life). Ask the patient to describe his/her family, social and work relationships to determine if these relationships are satisfying or troubling to the patient and to evaluate the effect the present condition has on your patient's role and relationships.

The assessment data here describes the patient's satisfaction, dissatisfaction or dysfunction with personal sexuality and describes the reproductive pattern. Elicit and document information about your patient's sexual and reproductive concerns.

Determine and document if and how the patient's present condition has affected sexual function or if there is a lack of knowledge relative to sexuality and/or reproduction.

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3.H UNIVERSAL REQ: PREVENTION OF HAZARDS TO LIFE FUNCTION AND WELL-BEING**ASSESSMENT DATA:**

Describe client's perceptions of his/her own health and well-being and describe how the client's health is managed. Describe his/her participation in health seeking practices (i.e. preventative screening, immunizations, nutrition and Exercise, etc.)

Elicit and document information about your client's knowledge of: (1) the health problem, (2) awareness of what should be done and (3) the ability to use appropriate resources to manage the problem.

Describe the medical treatment recommendations, medications and/ or regimes he/she complies with to maintain or improve health.

The assessment data here describes the patient's ability to see, hear, taste, touch and smell as well as the ability to communicate, understand, remember and make decisions regarding his/her own life choices. Elicit and document information about your patient's senses and cognitive ability as they relate to his/her ability to perform activities of daily living.

Questions regarding sensory deficits and the way your patient compensates for these deficits should be asked and noted.

Determine and document if and how the patient's present condition has interfered with the senses or cognition and how sensory-perceptual needs are being met.

If the patient's present condition has produced sensory deficits or symptoms such as memory loss, determine and document how these deficits are being compensated for and/or how the patient is being protected from harm.

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4. DEVELOPMENTAL ASSESSMENT

4.1 Identify the developmental stage (according to Erikson) for this client's age group. Explain the behaviors that relate to the tasks of this stage.

4.2 State the developmental level you perceive your client to be functioning at and substantiate your assessment. If applicable, substantiation should address what significance the current illness has on the stage of development.

5. DIAGNOSTIC ASSESSMENT/ANALYSIS GUIDE

Record all admission and most current diagnostic tests. Please utilize the form provided in the addendum section of this care plan.

** Diagnostic tests performed to assist in the determination of a medical diagnosis includes: blood work, x-rays, specimen cultures, scans, EKG's etc.*

LABORATORY TEST	ADMISSION TEST RESULTS	SUBSEQUENT TEST RESULTS (include date of test)	NORMAL LAB VALUE ACCORDING TO SEX & AGE	INTERPRETATION OF TEST RESULTS
<p><i>1. List each diagnostic test including both normal and abnormal results.</i></p>	<p><i>1. Document the date the test was performed and your patient's results.</i></p>	<p><i>1. Document the date the test was performed and your patient's results.</i></p>	<p><i>1. Document the normal lab value according to the sex and age of the patient listed in your current laboratory and diagnostic textbook.</i></p>	<p><i>1. Begin the interpretation by stating if the results are normal or abnormal. If abnormal, state how the result is abnormal (high, low, irregular, etc.) and compare the two test results.</i></p> <p><i>2. State why the result is abnormal for <u>your</u> patient. Relate the result to your patient's medical diagnoses.</i></p> <p><i>3. State what interventions are currently being performed to correct the abnormality. State whether or not the intervention is effective as evidenced by a change in value.</i></p> <p><i>For example: Hbg=8 gm on 9/2/04. This result is low, due to surgical blood loss during hip replacement surgery. The patient received 1 unit of packed RBC's on 9/3/04 and is currently receiving FsSo4 325 mg po dly.</i></p>

5. DIAGNOSTIC ASSESSMENT/ANALYSIS

Record all admission and most current lab data in the sections provided below. **Laboratory data includes diagnostic tests performed to assist in the determination of a medical diagnosis. Laboratory data includes blood work, x-rays, specimen cultures, scans, EKG's etc.*

Lab test	Admission test results	Subsequent test results (include date of test)	Normal lab value according to sex & age	Interpretation of test results

6. ORDERED INPATIENT MEDICATIONS:

Please list all medications ordered by the physician that your patient is currently receiving.

MEDICATION ORDER	CLASS	ACTION	INDICATION SPECIFIC TO YOUR PATIENT	SIDE EFFECTS	NURSING IMPLICATIONS

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