	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Document code: HSAAS/NURS/BR127**	Patient Sticker
	GENERAL NURSING ASSESSMENT	

Instruction:
Tick **(√)** and specify accordingly. Nursing assessment must be completed within 6 hours of admission.

PATIENT INFORMATION

Date And Time Admission @ Transfer In:	**Diagnosis**:
Primary Team: [ ] Neuro-medical [ ] IR [ ] Others:	**Reason for Admission**:
Admission from: [ ] RESQ [ ] Specialist clinic: [ ] Others(specify):	
Mode of arrival: [ ]walked -in [ ]Wheel chair [ ] Stretcher	
Accompany by: [ ] Hospital staff [ ] Family [ ] Friends [ ] Others (specify):	
Race: [ ] Malay [ ] Chinese [ ]India [ ]Others	Religion: [ ] Islam [ ]Buddha [ ] Hindu [ ] Others
Level Education: [ ] Primary [ ] Secondary [ ]Tertiary	Marital Status: [ ] Single [ ] Married [ ]Others
Employment status:	Spouse / Family contact No.:
Living Status: [ ] Alone [ ] Family [ ] Nursing home [ ] Others:	

PAST MEDICAL HISTORY

MEDICAL HISTORY

[ ] Infectious disease	[ ] Cardiac:	[ ]Hyper/hypotension	[ ]Diabetes
[ ] Arthritis:	[ ]Cancer:	[ ]Respiratory:	[ ]Renal:
[ ]Seizure:	[ ]Thyroid:	[ ]Stroke:	[ ]Gastro:
[ ] Others:			

SURGICAL HISTORY

Year	Types of Operation	Hospital

HOSPITAL ADMISSION HISTORY

Year	Reason Of Admission	Hospital

HISTORY

History Of Blood transfusion	[ ] Yes	[ ] No	Allergic History [ ] Drugs:
History of blood transfusion reaction	[ ] Yes	[ ] No	[ ] Food: [ ] Others:

FAMILY HISTORY

[ ] Father (Please specify):
[ ] Mother (Please specify):
[ ] Siblings (Please specify):

SOCIAL HISTORY

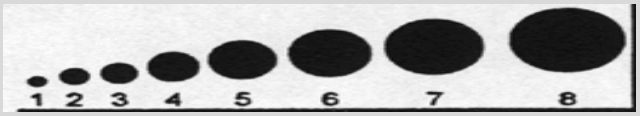
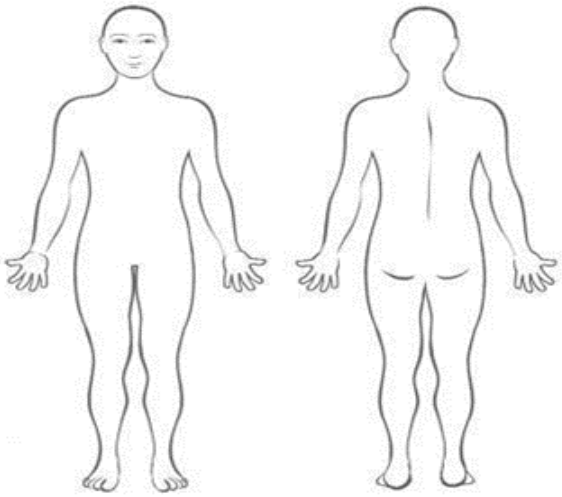
Do you use Tobacco? [ ] Yes (Currently) [ ] No [ ] Yes (In the past)

if yes, what type?..... How often?..... How Long in use?.....

Do you use alcohol? [ ] No [ ] Yes (Currently) [ ] Yes (In the past)

GENERAL ASSESSMENT			
Level of consciousness: [ ] Alert [ ] Drowsy [ ] Stupor [ ] Coma			
Oriented to: [ ] people [ ] place [ ] time [ ] Date			
Emotional Status: [ ] Cooperate [ ] Anxious [ ] Hostile [ ]			
Communication: [ ] Malay [ ] Chinese [ ] Indian [ ] English [ ] Aphasic [ ] Slurred Speech [ ] Incoherent			
ANTHROPOMETRY			
Weight			Kg
Height			Cm
BMI			
	LBW (BMI < 22.)	N: BMI 22-27	HBW (BMI >27
	OBESE 2(BMI 35-39.9)	OBESE 3(BMI > 40)	OBESE 3(BMI > 40)

PHYSICAL EXAMINATIONS

PUPIL		SKIN
		
Pupil Size (R):__ mm	[ ] respond to light	
	[ ] do not respond to light	
	[ ] Slightly respond to light	
	[ ] Fixed & Dilated	
Pupil Size (L):__ mm	[ ] respond to light	
	[ ] do not respond to light	
	[ ] Slightly respond to light	
	[ ] Fixed & Dilated	
		Mark where appropriate: R- Redness O – Oedema S- Swollen PS- Pressure Sore B- Blister H – Hematoma W – Wound
Hair: [ ] Clean [ ] Dirty [ ] Foul odour [ ] Dandruff		
Vision : [ ] Cataract- R/L [ ] Contact Lens [ ] Glasses [ ] Blind		Wound [ ] Yes [ ] No - Refer wound chart
Conjunctiva: [ ] Pale [ ] redness [ ] swollen [ ] Discharge [ ] Others:……		Temperature: [ ] Warm [ ] Hot [ ] Cold [ ]Moisture
Hearing: [ ] Hearing impaired [ ] Discharge		Colour : [ ] Pink [ ] Pallor [ ] Bluish
Nose/Throat: [ ] Nasal Congestion [ ] Sore throat		Skin Turgor: [ ] Normal [ ] Degenerate
Mouth: [ ] Pink [ ] Dry [ ] Ulcer [ ] Dentures		[ ] Others:
Chest		**Breast**
Breathing: [ ] Regular [ ] Irregular		[ ] Tender [ ] Discharge [ ] Pain [ ] Lump
Pattern: [ ]Normal [ ] Stridor [ ] Wheeze [ ] Dyspnoea		**Diet**
		Appetite: [ ] Good [ ] Poor [ ] Feeding Tube

ELIMINATIONS	
Gastrointestinal: Frequency: _____ Constipation [ ] Yes [ ] No Diarrhoea [ ] Yes [ ] No Laxative [ ] Yes [ ] No Incontinence [ ] Yes [ ] No Using Diapers [ ] Yes [ ] No	Genitourinary: Frequency: _____ Incontinence [ ] Yes [ ] No CBD [ ] Yes [ ] No Leak [ ] Yes [ ] No Using Diapers [ ] Yes [ ] No

MUSCULOSKELETAL

[ ] Free [ ] Joint Pain [ ] Stiff [ ] weak [ ] Cramps
[ ] Back Pain [ ] Contracture

MOBILITY -AMBULATION

[ ] independent [ ] supervised [ ] aided 1 person [ ] aided 2 person
[ ] Chairbound with transfers [ ] Complete Rest In Bed (CRIB) [ ] Bedbound

NURSING RISK ASSESSMENT

BRADEN SCALE PRESSURE INJURY RISK ASSESSMENT

Total scores less than 16: [ ] Yes [ ] No If YES indicate that patients is at risk for pressure injury

If Yes, Initiate Pressure Injury Prevention: [ ] Ripple Mattress [ ] 2 hourly positioning [ ] Barrier Product

PATIENT OWN MEDICATION (POM)	Level Of Care (√)	
	L1 -Self Care	
	L2- Partial	
	L3- Full Care	
	L4 -Critical	

NURSING DIAGNOSIS

□ Impaired Physical Mobility □ Impaired verbal [and/or written] Communication

□ Self- Care deficit □ ineffective Coping □ Acute pain

□ risk for impaired Swallowing □ Unilateral Neglect □ Risk for fall

□ Deficient Knowledge regarding condition, prognosis, treatment, self- care, and discharge needs

□ Risk for electrolyte imbalance □ Impaired urinary elimination □ Constipation

□ Disturbed sleep pattern □ Ineffective breathing pattern □ Acute confusion

□ Deficient knowledge □ Risk for infection □ Ineffective airway clearance

□ Risk for Ineffective Cerebral Tissue Perfusion □ Ineffective Coping □ Activity Intolerance

□ Imbalanced Nutrition: Less Than Body Requirements □ Impaired Skin Integrity

Other: Please specify

1.

2.

3.

4.

Assessment done by: RN Name: Date : Time:	Assessment completed by: RN Name: Date : Time:

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UNIVERSITI PUTRA MALAYSIA

NURSING KARDEX

Patient Sticker

Instruction:
All information or data must be updated at the end of each shift change accordingly.

TREATMENT AND INTERVENTION IN PROGRESS

NURSING OBSERVATIONS

Continuous Nursing Assessment and Monitoring (Tick √ if applicable)	
Vital Signs	
Random Sugar (Dextrostix)	
Morse Fall Scale	
Braden Scale Injury Risk Assessment	
Skin Assessment	
Thrombophlebitis Chart	
Glasgow Coma Scale (GCS)	
Wound Chart	
Intake and Output Chart	
NIHS chart:	
Modified 4 -AT:	

OXYGEN THERAPY

Types	Date Start	mls/hrs	Date off
Nasal Prong			
Face mask			
Venturi mask			
Trachy -mask			
HFM			
Others:			

(Tick √ if applicable):

Spirometry [ ] Additional:
Vena Flow machine [ ]

NUTRITIONAL (ORAL/ ENTERAL)

Type Of Diet	Date Started
Normal Diet	
Soft Diet	
Diabetic Diet	
Low Cholesterol, low salt	
Dysphagia Pureed diet	
Others:	

Enteral Feeding Regimen:

CANNULATION

Types	Start date	Due Change								
Peripheral Line										
Arterial line										
CVP/Triple Lumen line										
Urinary Catheter										
Ryle'S Tube										
Drainage/Chest Tube										

STROKE WORKOUT

PROCEDURE	Date Request	Date Plan
ECHO		
ECG		
TCD		
HOLTER		
CT BRAIN (Post Thrombolysis)		

REFERRAL

	Date Request	Date Review
Rehab		
Physiotherapy		
Dietitian		
Speech Therapy		
Occ. Therapy		

NURSING CONTINUOUS INTERVENTIONS	

Date	Intravenous Therapy

Date	Investigation

Date	Nursing/Medical Plan/treatment

Date	Intravenous Therapy

Date	Investigation

Date	Nursing/Medical Plan/treatment