DOWNTIME FORM

*** = POWERCHART REQUIRED FIELD**

ADULT ADMISSION PROFILE

ADMISSION INFORMATION

Arrival time: _____ Date: _____

Reason for admission: _____

GENERAL INFORMATION

Source of information:

☐ Patient ☐ Mother ☐ Son ☐ Immediate family
☐ Spouse ☐ Father ☐ Sister ☐ Friend
☐ Significant other ☐ Daughter ☐ Brother ☐ Medical record
☐ Unable to obtain ☐ Other: _____

Reason unable to obtain: _____

Accompanied by: ☐ Mother ☐ Son ☐ Immediate family
☐ Spouse ☐ Father ☐ Sister ☐ Friend
☐ Significant other ☐ Daughter ☐ Brother ☐ Other _____

Visitors restricted: ☐ Mother ☐ Son ☐ Immediate family
☐ Spouse ☐ Father ☐ Sister ☐ Friend
☐ Significant other ☐ Daughter ☐ Brother ☐ Other _____

Type of restriction _____	Information password _____
	Blood products preference: ☐ No blood products
Ethnic, Cultural or Spiritual practices that would affect care?	☐Yes ☐No
Does Patient/Family have concerns right now about this Hospitalization?	☐Yes ☐No
Does the patient wish to see a member of the hospital clergy?	☐Yes ☐No
Patient/Family oriented to room?	☐Yes ☐No

ADULT IMMUNIZATION

*Has patient had an influenza vaccine this season? *(applicable from September through March)*

☐ Yes ☐ No ☐ Not applicable – not flu season ☐ Unable to determine ☐ Unknown to patient

If Yes, injectable or nasal? ☐ Injectable ☐ Date of influenza vaccine _____
Unknown ☐ Nasal

*Has patient had a pneumococcal vaccine in the past 5 years?

☐ Yes ☐ No ☐ Unable to determine ☐ Date of pneumococcal vaccine _____
Unknown to patient

Has patient had a Hepatitis B vaccine?

☐ Yes ☐ No ☐ Unknown Date of Hepatitis B vaccine _____

Has patient had a diphtheria/tetanus vaccine?

☐ Yes ☐ No ☐ Unknown Date of diphtheria/tetanus vaccine _____

BO-D5003

DOWNTIME FORM

** = POWERCHART REQUIRED FIELD*

ADULT ADMISSION PROFILE

MEDICAL HISTORY

Medical history	☐ History reviewed ☐ Unable to obtain	☐ History updated ☐ Denies previous medical history

Name Of Problem	Last Reviewed	Age of Onset	Age Resolved	Resolved Date	Comments

SURGICAL HISTORY

Procedure	Last Reviewed	Procedure Date	Comments

SOCIAL HABITS

Category	Type/Frequency	Details		Comments
Alcohol	☐ Beer ☐ Wine ☐ Liquor ☐ Other:	Frequency: ☐ 1-2x year ☐ 1-2x month ☐ 1-2x week ☐ 3-5x week ☐ Daily ☐ Several x Day	Age Started:_____ Age Quit:_____ Interfere w/Home Life?. Drink more than intended? Ready to change? Concerns about ETOH?	Any Previous Tx?
Substance Abuse	☐ Amphetamine ☐ Cocaine ☐ Ecstasy ☐ Hallucinogens/LSD ☐ Heroin ☐ Inhalants/huffing ☐ Marijuana ☐ Methamphetamine ☐ Prescription drug ☐ Other:	Frequency: ☐ 1-2x year ☐ 1-2x month ☐ 1-2x week ☐ 3-5x week ☐ Daily ☐ Several x Day	Age Started:_____ Age Quit:_____ I/V Drug Use? Interfere w/Home Life?. Ready to change? Concerns about substance abuse in household?	Any Previous Tx?

[redacted]

DOWNTIME FORM

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ADULT ADMISSION PROFILE

Home/Environment	Lives With: ☐ Alone ☐ Children ☐ Father ☐ Mother ☐ Siblings ☐ Significant other ☐ Spouse ☐ Other:	Living Situation ☐ Home/Independent ☐ Home w/Assistance ☐ Nursing Home ☐ Hospice ☐Homeless/Shelter	Home Equipment: ☐ CPAP/BiPAP ☐ Elevator ☐ Feeding Tube ☐ Glucose monitoring ☐ IV Therapy ☐ Monitoring ☐ Oxygen ☐ Respiratory Tx ☐ Special Bed ☐ Ventilator ☐ Walker/Cane ☐ Wheelchair ☐ Other:	Household issues: ETOH Abuse *In Household*? Substance Abuse? Smoking? Inquires/Abuse/Neglect? Type of Abuse:
Religious Restrictions/concerns: ☐ Blood Products ☐ Dietary Restrictions ☐ Same Gender Caregiver ☐ Other:	Feels Unsafe at Home? Safe Place to go? Agencies/Others Notified?(Please List)	Family/Friends available to help? Concern for Family members at home? Major Illness at home? Financial Concerns? Concerns about TV/Computer/Game use?	Other Environmental Risks: ☐ Unlocked Guns ☐ Chemicals/Paint ☐ Pets/Animals ☐ Stairs ☐ Pool/Water ☐ Other(specify below)	Current Sensory Status: Blind R eye☐ L eye☐ Deaf R ☐ L☐ HoH R ☐ L☐ Legally Blind R☐ L☐ Mute ☐ Speech Deficit ☐
Nutrition/Health	☐Regular ☐Calorie Restricted ☐ADA ☐Vegetarian ☐Other:	Diet Description: Restrictions: Supplements:	Wants to lose weight? ☐ Bulimia ☐Anorexia Nervosa ☐ Overeating ☐ Other:	Wants to lose weight? Sleeping Concerns? Feels highly stressed?	Alternative healthcare? Comment:
Employment/School	☐ Employed ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed ☐ Other: Description	Previous employment/school: Activity Level ☐ Desk/Office ☐ Occasional Physical work ☐ Moderate Physical work ☐ Heavy Physical work	Work Hazards: ☐ Hazardous Materials ☐ Heavy lifting/twisting ☐ Loud Noises ☐ Medical/Clinical Work ☐ Repetitive Motion ☐ Shift/NOC work ☐ Vibration ☐ Other:	School Concerns: ☐ Learning ☐ Social ☐ Communication ☐ Health ☐	
Exercise	Duration (avg in minutes): Times Per Week: ☐ 1-2 xweek ☐ 3-4 xweek ☐ 5-6 xweek ☐ Daily	Self Assessment: ☐ Poor Condition ☐ Fair condition ☐ Good Condition ☐ Excellent condition	Exercise Type ☐ Walking ☐ Aerobics ☐ Running ☐ Swimming ☐ Weight Lifting ☐ Yoga ☐ Other:	Comments:	

DOWNTIME FORM

* = ***POWERCHART REQUIRED FIELD***

ADULT ADMISSION PROFILE

Sexual	Sexually active? Age first active: Current Partners: # of lifetime partners: Self Described Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgendered	Contraceptives used: History of Sexual Abuse?	Other Sexual concerns	Comments:
Other	Name:	Details	Comment:	

AUDIT-C

*How often did you have a drink containing alcohol in the past year?	☐ Never (0) ☐ Less than monthly (1)	☐ 2-4 times/month (2) ☐ 2-3 times/week (3)	☐ 4 or more times per week
*In the past year, how many drinks did you typically have when you drank?	☐ 1 or 2 (0) ☐ 3 or 4 (1)	☐ 5 or 6 (2) ☐ 7 to 9 (3)	☐ 10 or more (4)
*How often did you have 6 or more drinks on one occasion in the past yr?	☐ Never (0) ☐ Less than monthly (1)	☐ Monthly (2) ☐ Weekly (3)	☐ Daily (4)
*Have you ever been treated for an alcohol problem or attended AA?	☐ Yes ☐ No		
*For scores of 4 or greater, provide alcohol use information literature. *For scores of 7 or greater, also notify attending physician.	Literature offered? ☐ Yes ☐ No Physician notified? ☐ Yes ☐ No		

TOBACCO HISTORY

*Smoking Status: ☐ Never Smoker ☐ Current Everyday Smoker ☐ unknown if ever smoked
☐ Quit more thatn 1 year ago ☐ Current Some Day Smoker
☐ Quit within the Past year ☐ Smoker current status unknown

Type of Tobacco:	Date Quit:	Years of Tobacco Use:	*Tobacco Use Cessation Information offered:	*Patient Accepted Information:
☐ Cigar				☐ Yes
☐ Cigarettes	Age Started:			☐ No
☐ Pipe		Others in House	☐ Yes	☐ Not Applicable
☐ Chewing Tobacco	Amount of Tobacco Use	Smoke?	☐ No	
☐ Snuff	Daily (in packs):		☐ Not applicable	

ABUSE/NEGLECT SCREENING

If Yes is selected, please notify Social Services Immediately.

*Have you ever been emotionally or physically abused by your partner, caregiver or someone important to you?	☐ Yes ☐ No ☐ Unable to obtain	Patients should be interviewed alone, if at all possible Select "unable to obtain" if patient is accompanied by visitor.
*Within the past year, have you been hit, kicked or otherwise physically hurt by someone?	☐ Yes ☐ No ☐ Unable to obtain	
*Within the past year, has anyone forced you to have sexual activity?	☐ Yes ☐ No ☐ Unable to obtain	

[redacted]

DOWNTIME FORM

*** = POWERCHART REQUIRED FIELD***

ADULT ADMISSION PROFILE

*Are you afraid of your partner, caregiver or anyone else?	☐ Yes ☐ No ☐ Unable to obtain	Abuse/Neglect/Exploitation Comment:
*Clinician/Family believe that neglect or exploitation may exist?	☐ Yes ☐ No ☐ Unable to obtain	

SELF HARM RISK SCREENING

"As I ask these questions, please think about the past two weeks." If Yes is selected, please notify Social Services for Suicide Consult.

*Have you ever felt life was not worth living? ☐ Yes ☐ No ☐ Unable to obtain
If Yes please explain:

*Is death something you've thought about recently? ☐ Yes ☐ No ☐ Unable to obtain
If Yes please explain:

*Have things ever reached the point that you've thought of harming yourself? ☐ Yes ☐ No ☐ Unable to obtain
If Yes please explain:

*Did you ever wish you could go to sleep and just not wake up? ☐ Yes ☐ No ☐ Unable to obtain
If Yes please explain:

*Is death something you've thought about recently? ☐ Yes ☐ No ☐ Unable to obtain
If Yes please explain:

*Have things ever reached the point that you've thought of harming yourself? ☐ Yes ☐ No ☐ Unable to obtain
If Yes please explain:

*Clinician/family believes suicidal intent/behavior may exist? ☐ Yes ☐ No
If Yes please explain:

BRADEN ASSESSMENT

*Sensory Perception: ☐ Completely limited (1) ☐ Very limited (2) ☐ Slightly limited (3) ☐ No impairment (4)	*Moisture: ☐ Constantly moist (1) ☐ Very moist (2) ☐ Occasionally moist (3) ☐ Rarely moist (4)	*Activity: ☐ Bedfast (1) ☐ Chairfast (2) ☐ Walks occasionally (3) ☐ Walks frequently (4)
*Mobility: ☐ Completely limited (1) ☐ Very limited (2) ☐ Slightly limited (3) ☐ No limitations (4)	*Nutrition: ☐ Very poor (1) ☐ Probably inadequate (2) ☐ Adequate (3) ☐ Excellent (4)	*Friction and Shear: ☐ Problem (1) ☐ Potential problem (2) ☐ No apparent problem (3)

Skin Integrity Risk Score _____ (total)
*The patient is at risk for skin breakdown when the Skin Integrity Risk Score is less than or equal to 18.

MORSE FALL SCALE

*Patient has a history of falling? ☐ No (0) ☐ Yes (25)	Include falls during the present admission and/or within 2 weeks or less of hospitalization.

DOWNTIME FORM

*** = POWERCHART REQUIRED FIELD***

ADULT ADMISSION PROFILE

*Patient has a secondary diagnosis? ☐ No (0) ☐ Yes (15)	Includes any secondary diagnosis listed in the medical record.
*Patient uses ambulatory aid? ☐ None/bed rest/nurse assist (0) ☐ Crutches/cane/walker (15) ☐ Furniture (30)	Includes all ambulating patients. If not ambulating or using a wheelchair, score =0.
*Patient has IV therapy/heparin lock? ☐ No (0) ☐ Yes (20)	
*Patient's gait: ☐ Normal/bed rest/wheelchair (0) ☐ Weak (10) ☐ Impaired (20)	Normal gait – walking with head erect, arms swinging freely at the side and striding unhesitantly = 0 Weak gait – stooped but is able to lift the head while walking without losing balance. Steps are short and may be shuffling. Support is only featherweight touch for reassurance, rather than grabbing to remain upright = 10 Impaired gait – difficulty rising from chair, attempting to get up by pushing on the arms of the chair and/or by bouncing. Head is down, balance poor, grasps onto furniture, person, or walking aid and cannot walk without assistance. Short steps/shuffles. = 20 If patient is in a wheelchair, score according to the gait used when transferring from the wheelchair to the bed.
*Patient's mental status: ☐ Oriented to own ability (0) ☐ Overestimates/forgets limitations (15)	
Morse Fall Score: _____ *☐ Patient's medications reviewed	
Is patient considered at risk for a fall? A Morse fall score of 45 or above places the patient at risk for a fall. Patient's medication regimen may also place patient at risk for a fall.	
Consider putting patient at risk for a fall if patient is on four or more medications, taking high-risk medications, or has had recent changes to their medication regimen.	
*☐ **Yes**, the current medications AND/OR the Morse Fall Score of 45 or greater places the patient at risk for falling.	
*☐ **No**, based on the medications reviewed AND/OR the Morse Fall Score of 45 or less, a fall-free environment should be maintained.	

NUTRITION SCREENING

If Yes is selected please enter a Dietary Consult when Downtime is concluded

Does the patient feel they require more education regarding the special diets?	☐ Yes ☐ No ☐ Unable to obtain	☐ Other:
Has the patient recently been on tube feedings or TPN, or do they have a nutritional access device in place?	☐ Yes ☐ No ☐ Unable to obtain	☐ Other:
*Has patient had an unintentional weight change greater than 10 lbs. within past 3 months?	☐ Yes ☐ No ☐ Unable to obtain	☐ Other:

Reported weight loss:	**Reported Weight Gain:**	
*Has here been a reduction in food in take or hydration, e.g., has patient reported eating less than half of usual food intake in past 7 days?	☐ Yes ☐ No ☐ Unable to obtain	☐ Other:
*Does patient have any large open wounds or wounds that are not healing?	☐ Yes ☐ No ☐ Unable to obtain	☐ Other:
*Has the patient had gastric bypass surgery within the past year?	☐ Yes ☐ No ☐ Unable to obtain	☐ Other:

DOWNTIME FORM

*** = POWERCHART REQUIRED FIELD**

ADULT ADMISSION PROFILE

VALUABLES/BELONGINGS

See Valuables and Belongings downtime form.

FUNCTIONAL SCREENING/DISCHARGE PLANNING

(Within the last 6 months) Does patient have new difficulties with dressing, bathing, or household activities?
☐ Yes ☐ No ☐ Unable to obtain

(Within the last 6 months) Does patient have new difficulty with speech, memory, or problems with communication?
☐ Yes ☐ No ☐ Unable to obtain

(Within the last 6 months) Does patient have new difficulty with strength, balance, or walking which interfere with everyday activities?
☐ Yes ☐ No ☐ Unable to obtain

*Does patient have difficulty chewing, swallowing, or coughing when drinking fluids?
☐ Yes ☐ No ☐ Unable to obtain

*Does patient have new difficulty with hearing or vision?
☐ Yes ☐ No ☐ Unable to obtain

☐ Yes ☐ No ☐ Unable to obtain

Does the Patient Need any of the following types of discharge assistance?
☐ Equipment ☐ Home Care ☐Other:
☐Financial ☐ Hospice

Does the patient need discharge assistance from anyone of the following?
☐ Care Coordinator ☐Discharge Planner ☐Other
☐ Case Manager ☐ Social Work

Current assistive Services:
☐Adult day care ☐Hemodialysis ☐Hospice ☐Housekeeping ☐Social Services
☐Transportation
☐Care Management ☐ Home Care Agency ☐Hot Meals Delivered ☐Respite Cares ☐ Telephone Monitoring
Hemodialysis Location/Schedule:

Functional/ADL Level at Home:
☐Help with ambulation ☐Unable to bathe self ☐Unable to feed self ☐Other:
☐Total Lift ☐Unable to dress self ☐ Unable to speak

Number of steps into the home:	Bathroom on main floor? ☐Yes ☐No	Bedroom on main floor? ☐Yes ☐No

DISCHARGE PLAN

Plan to return home	☐Yes ☐No ☐Unknown ☐Comment:
Transportation Assistance Post Discharge	☐Yes ☐No ☐Unknown ☐Comment:
Home assistance Post Discharge	☐Yes ☐No ☐Unknown ☐Comment:

SIGNATURE/CO-SIGNATURE/DATA VALIDATION

DATE/TIME	SIGNATURE
CO-SIGN	CO-SIGNER'S NAME
☐ I have reviewed this document and verify that it is accurate.	
☐ I have reviewed this document and verify that it is accurate.	
☐ I have reviewed this document and verify that it is accurate.	

Have you been to _____ before this visit? Yes _____ No _____

If Yes, when: _____

Date: _____ Time: _____

****

PATIENT INFORMATION: (Please clearly print Full Legal Name)

Last Name _____ First Name _____ MI ____

DOB ____/_____/_____ Social Security Number _____

Mailing Address _____

City/State/Zip _____

Home phone number (_____) _____ Work or cell phone number (_____)-_____

PARENT INFORMATION (for patients younger than 18 years old):

Relationship to Patient: _____ Date of Birth _____/_____/_____

Last Name _____ First Name _____ MI ____

Mailing Address _____

City/State/Zip _____ Home phone (_____) _____ Social

Security Number _____ Work/Cell Phone (_____) _____

Employment Status: Full/PT/Self/Not Emp/Ret/Dis/Unk (please circle one)

Retirement Date (if applicable) _____/_____/_____

****

PRIMARY INSURANCE

Subscriber Name _____ Relation to patient _____

Subscriber Date of Birth ____/_____/_____ Subscriber Employer _____

Policy Number _____ Group Number _____

****

SECONDARY INSURANCE

Subscriber Name _____ Relation to patient _____

Subscriber Date of Birth ____/_____/_____ Subscriber Employer _____

Policy Number _____ Group Number _____

****

(Medicaid patients only)

Primary Care Physician name: _____