

Nursing Patient Assessment Form

Pharmacy _____

Pharmacy Phone _____

ASSISTIVE DEVICES (check all that apply)

Hearing aid(s) _____ Glasses _____ Contacts _____
Crutches _____ Walker _____ Cane _____
Wheelchair _____

PSYCHOSOCIAL/COPING

Primary Language _____ Interpreter needed Y / N

With whom do you live? _____

Are there any family members (or others) with whom we ***should not*** share information?

(Please list names) _____

May we leave messages on your answering machine? Y / N

Is there anyone at home willing/able to assist with healthcare, if needed? Y / N

Do you have problems sleeping? Y / N

Would you like information or assistance with: (check all that apply)

Cancer support groups _____	Complementary therapies _____
Family counseling/support _____	Financial concerns _____
Medical supplies/equipment _____	Nutrition issues _____
Meal preparation/household help _____	Spiritual support _____
Transportation _____	Workplace issues/concerns _____

Referral Made Y / N To Whom _____

EDUCATIONAL ASSESSMENT

Who would you like included in patient education sessions? _____

How do you learn best?

Written _____ Verbal _____ Video _____
Hands on _____ Demonstration _____

Are there any barriers to learning? If yes, describe _____

BASELINE VITALS (nurse to complete)

Ht _____ Wt _____ T _____
Pulse _____ BP _____ Resp _____

Patient/Other Signature _____ **Date** _____

Nurse Signature _____ **Date** _____

