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University of Maryland Medical Center
Ambulatory Services

3-Hole 5/16 4 1/4 c-to-c

Initial Assessment

PATIENT IDENTIFICATION

I. Risk Assessment

A. Nutritional Risk: ☐ See also MD/Nurse Practitioner Note Person supplying information _____
Height _____ Weight _____
☐ Unintentional weight loss of ≥ 10 lbs. over a 1 month period
☐ Untreated chronic medical condition
☐ Non-healing wound
☐ **Patient reports the following and needs nutrition consult/intervention:**
☐ Type 1 or 2 diabetes mellitus ☐ End-stage liver disease
☐ Anorexia nervosa/bulimia nervosa ☐ Celiac disease
☐ Other _____
☐ None

Pediatrics:
☐ Failure to thrive (see guideline)
☐ Multiple food allergies
☐ End-stage renal disease (Peds Only)
☐ Cerebral palsy (Peds Only)

B. Physical and Cognitive Functional Risk:
☐ Mobility/positioning deficits (bed mobility, transfers, ambulation)
☐ Difficulties with ADL's (feeding, dressing, bathing)
☐ Speech / language / cognitive deficits
☐ Swallowing deficits

Additional Pediatric Risks:
☐ Development delays
☐ Seating /positioning needs
☐ Oral-motor deficits

Fall risk (If one or more risk factors are present, complete the Fall Risk Assessment and Prevention Plan, electronically or on form #HW003).
☐ History fall ☐ Impaired balance/gait ☐ Impaired Mobility ☐ Impaired Vision ☐ Medication side effect
☐ Mental Status Change ☐ Muscle Weakness ☐ Post Anesthesia
☐ Orthopedic patient
☐ None

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C. Psychosocial Risks: ☐ Substance Abuse Called X8-6169 ☐ Social Work Called X8-6700 ☐ None
☐ Patient smokes, quit smoking less than one year ago, or, if pediatric, lives with someone who smokes - smoking cessation information given
☐ Drug/alcohol/substance abuse ☐ Depressed/suicidal ☐ Financial need
☐ Adaptation to illness or terminal illness ☐ No family support/involvement ☐ Other (specify) _____
☐ Abuse/neglect/violence (for cues related to suspected risks, see policies for assessment of patient — AOP 003, 004, 005, and 006)

D. Psychosocial Functional Risks: ☐ Ineffective, independent living skills ☐ Impulsivity/acting out ☐ None

E. Pain Screening: (If answer is yes, complete the pain assessment/history if pain is relevant to visit)
Pain present now? ☐ Not relevant to visit ☐ No ☐ Yes per ☐ Patient ☐ Family ☐ Tool
Current history of pain? ☐ Not relevant to visit ☐ No ☐ Yes per ☐ Patient ☐ Family ☐ Tool

F. Exposures (within last 6 months): ☐ TB ☐ Chicken Pox ☐ None Other (specify) _____
Immunizations up-to-date (Peds) ☐ Yes ☐ No

G. History of resistant organisms: ☐ VRE ☐ MRSA ☐ None ☐ Other (specify) _____

H. Allergies: ☐ No ☐ Yes ☐ Medication ☐ Food ☐ Unknown ☐ Other _____
Latex Allergy: ☐ No Allergy ☐ Latex Risk (frequent exposure to latex) ☐ Latex Allergic
Allergy Information: _____

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I. Advance Directive ☐ Yes ☐ No ☐ N/A ☐ Copy in chart ☐ Info given
☐ Patient **does not want** to complete advance directive.
☐ Patient **wants** to complete advance directive.

Behavioral Health Directive ☐ Yes ☐ No ☐ N/A ☐ Copy in chart ☐ Info given
☐ Patient **does not want** to complete behavioral health directive.
☐ Patient **wants** to complete behavioral health directive.

J. Spiritual / Cultural Assessment: Ask the patient to finish this sentence: My Spiritual and/or religious beliefs . . . ☐ are an important part of my life
☐ are not an important part of my life ☐ are a source of conflict.
Ask the patient: "Are there any cultural considerations we should consider while you are in our care?" ☐ Yes ☐ No

Risk Notification: ☐ No referral/notification needed ☐ Already in treatment ☐ Social Work ☐ Psychiatry ☐ Wound, ostomy, continence
☐ Nutrition ☐ Home Health ☐ Primary Care Provider with recommendation for: _____
☐ OT, PT, or Speech (circle all that apply) ☐ Other _____

II. Patient/ Family Education Assessment

Able to understand care plan/routine teaching: **Patient:** ☐ Yes ☐ No **Family:** ☐ Yes ☐ No

Desire / Motivation to Learn:
Patient: ☐ Involved ☐ Passive learner ☐ Averts attention, disinterested ☐ Unable to assess because of age/ development or patient condition
Family: ☐ Involved, asks questions ☐ Passive listener ☐ Averts attention, disinterested ☐ Unable to assess at this time

Patient/ Family Preference: ☐ Verbal teaching ☐ Written material ☐ Demonstration ☐ Video ☐ Other _____

Teaching Needs:
☐ Medication ☐ Rehabilitation technique ☐ See Pathway
☐ Medical Equipment ☐ Community resources ☐ See Core Measures Education Tool
☐ Diet/Nutrition ☐ Personal hygiene ☐ Food/drug interaction
☐ Pain management ☐ None

Barriers to Learning (specify below):
☐ Level of consciousness ☐ Level of motivation ☐ Education ☐ Emotional barrier ☐ Language ☐ Sensory deficit
☐ Developmental age ☐ Cognitive impairment ☐ None ☐ Other _____

Practitioner Signature/Title: _____

Date/Time: _____

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