OSWALDO CRUZ
HOSPITAL ALEMÃO

LABEL

INITIAL EVALUATION

☐ Inpatient ☐ Outpatient

RISKS		
ALLERGIES:	☐ Fall ☐ PU ☐ Phlebitis ☐ Other:	See specific routine

I - INTERVIEW - INITIAL DATA FOR ADMISSION / TREATMENT

What does the patient know about the reason for admission / attendance? (Write down as reported by patient).

PREVIOUS ADMISSIONS/ SURGERY RADIOTHERAPY/CHEMOTHERAPY	LOCATION / TYPE	DATE OF PROCEDURE	INSTITUTION	NOTES! ANESTHETIC COMPLICATIONS

PERSONAL HISTORY / HABITS

1. Fasting	☐ No	☐ Unknown	☐ Yes	Since what time?	
2.Diabetes	☐ No	☐ Unknown	☐ Yes	Since when?	Type:
3.High Blood Pressure?	☐ No	☐ Unknown	☐ Yes		
4.Cardiopathies	☐ No	☐ Unknown	☐ Yes	Which?	
5.DVT / PTE	☐ No	☐ Unknown	☐ Yes	How long ago?	
6. Infectious and Contagious Diseases	☐ No	☐ Unknown	☐ Yes	Which?	
7. Other diseases	☐ No	☐ Unknown	☐ Yes	Which?	
8. Smoking		☐ No	☐ Yes	How many cigarettes/day?	☐ Quit smoking - How long ago?
9.Alcoholism		☐ No	☐ Yes	Amount / day	☐ Quit drinking - How long ago?
10. Physical activity		☐ No	☐ Yes	Frequency:	
11.Sleep and rest	☐ Queit	☐ Restless	☐ Insomnia	☐ Sleep apnea	☐ Other alterations:

NUTRITIONAL ASPECTS

Verifield weight: kg	Height: m	- Weight loss in the last 3 months? ☐ No ☐ Yes - Kg: - Reduced food intake in the last week? ☐ No ☐ Yes - History of: ☐ Lymphoma/Leukemia ☐ Bone marrow/organ transplant ☐ CRF ☐ Chronic Liver Disease ☐ Cancer of the head / neck ☐ Gastrointestinal cancer in clinical / surgical treatment ☐ Yes to item 6 of the personal history	2 yes: Activate Nutritionist (Nutrition Care)
Usual weight: kg	BMI: (BMI = Weight / Height 2)		

☐ Oral Diet - Acceptance / Restrictions:

☐ Supplements ☐ Nutrition Service ☐ Gastrostomy ☐ Jejunostomy Date of implant: / /

OSWALDO CRUZ
HOSPITAL ALEMÃO

DRUG RECONCILIATION Mark an X for medication brought from home

*	Name / Route / Dose	Time	*	Name / Route / Dose	Time
☐			☐		
☐			☐		
☐			☐		
☐			☐		
☐			☐	Activate Pharmacist for validation of non-standardized medication	

SOCIAL, ECONOMIC AND SPIRITUAL ASPECT

☐ Lives alone ☐ Lives w/ family/other ☐ Home Care Others:

Caretaker: ☐ No ☐ Yes ☐ Formal ☐ Informal - Who?

Economic status: ☐ Independent ☐ Dependent - On who?

Occupation: Religion belief:

Where necessary, activate social worker for evaluation and guidance

Hindrances to degree of communication: Understands the Portuguese language? ☐ Yes ☐ No - Note:

Level of education: ☐ Sight/Hearing Deficit ☐ Neurological Deficit ☐ Others:

Adapt forms of communication

I HEREBY CONFIRM THE DATA ABOVE

Name: Identification / Guardian:

Signature: ID: Date: / / Time: :

II - PHYSICAL EXAMINATION / VITAL SIGNS.

BP: mmHg	P: bpm	RR: mr / min	0^2: l / min
Base BP: mmHg	☐ Filform ☐ Full	Sat0^2: %	Device:
	☐ Rhythmic ☐ Arrhythmic		

Temp: ° C

PAIN: ☐ No ☐ Yes - Score: Location: Type:

PAIN Scale used:

See Medical Care PAIN Management Protocol

LEVEL OF CONSCIOUSNESS / EMOTIONAL ASPECT

Neurological: ☐ Alert ☐ Oriented ☐ Disoriented ☐ Non-verbal ☐ Intoxicated ☐ Sleepy ☐ Agitated

Glasgow Coma Scale: ☐ Not applicable ☐ Other alterations:

Emotional: ☐ Calm ☐ Tense ☐ Agitated ☐ Apathetic ☐ Euphoric ☐ Tearful ☐ Hopeless ☐ Other alteration:

HEAD AND NECK

Alopecia	☐ No	☐ Yes
Visual Acuity	☐ Normal	☐ Altered - Specify:
Nose	☐ No alterations	☐ Altered - Specify:
Mouth	☐ No alterations	☐ Altered - Specify:
Prosthodontics	☐ No	☐ Yes - Which?

Hearing Acuity: ☐ Normal ☐ Altered ☐ Right Ear ☐ Left Ear Hearing Aids: ☐ No ☐ Yes

Other alterations:

THORAX

Vesicular murmur: ☐ Present ☐ Absent ☐ Decreased - Location: RS: ☐ Rhonchi ☐ Rales ☐ Wheezing - Location:

Cough: ☐ No ☐ Yes ☐ Dry ☐ Productive - Secretion aspect:

Tracheostomy: ☐ No ☐ Yes ☐ Metallic ☐ Plastic - Date of Implant: / /

Catheters / drains: ☐ No ☐ Yes - Location: Date of Implant: / /

Other alterations:

OSWALDO CRUZ
HOSPITAL ALEMÃO

ABDOMEN

☐ Flat ☐ Distended ☐ Flaccid ☐ Pendulous ☐ Excavated Bowel sound: ☐ Absent ☐ Present ☐ Increased ☐ Decreased

Catheters / drains: ☐ No ☐ Yes - Location: Date of Implant: / /

Other alterations:

GENITOURINARY / INTESTINAL

Urinary: ☐ No alterations ☐ Incontinence ☐ Dysuria ☐ Polyuria ☐ Hematuria ☐ Anuria ☐ Nocturia ☐ Pollakiuria

☐ Indwelling Urinary Catheterization / Cystostomy / Urostomy - Date of Implant: / / Other alterations:

Intestinal: ☐ No alterations ☐ Incontinence ☐ Diarrhea ☐ Constipation ☐ Melena ☐ Enterorrhagia ☐ illeostomy / Colostomy

Date of Implant: / / Date of last bowel movement: / / Other alterations:

Menstruation: ☐ No alterations ☐ Menopause ☐ Not applicable ☐ Altered - Specify:

UPPER AND LOWER LIMBS / LOCOMOTION

☐ Bedridden ☐ Strolling - With support ☐ No ☐ Yes - Specify:

Movement: ☐ Normal ☐ Ataxic ☐ Asthenia ☐ Limping ☐ Immobilization - Specify:

☐ Paresis: ☐ Paresthesia: ☐ Plegia:

☐ Amputation - Location: ☐ Prosthesis / Orthosis - Location:

Peripheral perfusion: ☐ Present ☐ Absent ☐ Increased ☐ Decreased - Specify:

☐ Edema - Specify:

Other alterations:

SKIN ASPECT

Mucocutaneous Integrity: ☐ Integrity ☐ Injury - Specify:

Color: ☐ Rosy ☐ Discolored ☐ Jaundiced ☐ Cyanotic ☐ Others:

ADDITIONAL INFORMATION

Has been given the Rights and Responsibilities Handbook? ☐ No ☐ Yes

Has brought in exams? ☐ No ☐ Yes - Which:

Other information:

NEED FOR MULTIPROFESSIONAL EDUCATION - Specify

Person involved in education process: ☐ Patient ☐ Accompanying adult or family member

☐ Pre-surgical:

☐ Post-surgical:

☐ Self care / daily life habit:

☐ Post-discharge:

☐ Food Habits / Diet Therapy

☐ Specialized tretment:

☐ Others:

Signature - Stamp: Date: / / Time: :