Patient Admission Assessment

Special Needs: _____
(sensory impaired, cultural, language, etc)

Admission Time _____

Patient Sticker

VITAL SIGNS	MEDS TAKEN/LAST DOSE	PREOP CHECKLIST
Temp: _____ BP: _____ P: _____ R: _____ SaO2: ____on ____ Height: _____ Weight:_____ Age:_____ LOC: _____ NPO since: _____ Pain on 0-10 scale_____ ☐ See note Accu Check_____Time____ ☐ N/A	1. 2. 3. 4. 5. 6. 7. 8. ☐ **No Meds Taken Today**	☐ H&P on chart ☐ Lab/EKG on chart ☐ N/A ☐ Surgical Site Marked/Verified @_____(time), by_____(initial) ☐ Lens Verified, by_____ (initial) ☐ ID/Allergy Band ☐ Allergies Noted ☐ Consent signed ☐ Pregnancy Test _____ ☐ N/A ☐ Glasses/Contact removed ☐ N/A ☐ Dentures: upper / lower ☐ N/A ☐ Hearing Aid L/R removed ☐ N/A **Valuables Disposition** ☐ Family ☐ Locker/#_____ ☐ w/ Patient

☐ **Health History Questionnaire reviewed and signed by patient**

IV: Saline Lock_____ Site _____ Gauge _____ Time:_____

Solution Type/Amount _____ RN Signature _____

MEDICATION

☐ **No Medications Given**

Medication	Dose	Route	Time	RN	Medication	Dose	Route	Time	RN

Eye Medications	Gtts	Eye	Time/Initial	Time/Initial	Time/Initial	Time/Initial
Proparacaine 0.5%						
Dilating compound #1						
Phenylephrine 2.5%						
Cyclogel 1%						
Tropicamide 1%						
Acular						
Zymar/Vigamox						
Phenylephrine 10%						
Atropine 1%						
Iopidine/Alphagan						
Xylocaine 2% jelly (Just prior to transfer)	1 strip					

Time Transferred to OR_____

NursingNotes:_____
_____ (use back if needed)

RN Signature _____ Date: _____

RN Signature _____ Date: _____