New Admission Sample Questionnaire

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Name: _____ Admit date: _____

Suggested Introduction Script: Our goal is to ensure that we are providing you with the most person-centered care possible during your stay with us. To do this, we need some information from you. Over the first week or two of your stay, different team members will be coming to see you to ask additional questions about your pain, mood, and preferences, all with the goal of creating the most appropriate plan of care to meet your needs.

1. Please tell us about your goals and expectations during your stay with us:

a. What are your concerns about your stay here?

Describe: _____

_____

_____

b. If on a skilled stay, briefly discuss the requirements of the pay source (i.e., Medicare Part A, Medicare Advantage plan, insurance)

Describe: _____

_____

_____

2. What is your overall goal for your stay?

- ☐ Discharge to the community
- ☐ Remain in this facility
- ☐ Discharge to another facility
- ☐ Unknown or uncertain

a. If discharging to the community: What type of self-care training do you think you will need to be successful with your discharge back to the community?

Self-care of:

- ☐ Injections
- ☐ Diabetic care
- ☐ Ostomy care
- ☐ Tube feeding
- ☐ Toilet use
- ☐ Not sure
- ☐ Medications
- ☐ Wound care
- ☐ Catheter care
- ☐ ADLs
- ☐ Other: _____
- ☐ Other: _____

b. If discharging to the community: What resources/equipment do you have available to assist you after discharge?

☐ Has own equipment (i.e., cane, stair lift, grab bars)

Describe: _____

Describe: _____

Describe: _____

- ☐ Devices used at home
  - ☐ Manual wheelchair
  - ☐ Motorized wheelchair and/or scooter
  - ☐ Mechanical lift
  - ☐ Walker
  - ☐ Orthotics/Prosthetics
- ☐ Has caregiver assistance - Number of hours per day: _____
- ☐ Has home care services – Specify agency: _____
- ☐ Other (i.e., meals-on-wheels, home cleaning service)
  - Describe: _____
  - Describe: _____
  - Describe: _____

3. Please describe your daily routine prior to your current illness/injury:

a. What time do you prefer to wake up in the morning? _____

b. Toileting routine

i. Do you have any functional difficulties using the bathroom (i.e., getting to the toilet, adjusting clothes)?
☐ Independent ☐ Needed some help ☐ Dependent
Describe: _____

ii. Do you have any urinary or bowel concerns (i.e., difficulty starting stream, dribbling, constipation)?
Describe: _____

iii. How often do you have a bowel movement?
Describe: _____

iv. Did you have an established bowel regimen at home (i.e., daily prunes)?
Describe: _____

c. Did you receive assistance with any of the following activities at home?

i. Meal preparation?
☐ Independent ☐ Needed some help ☐ Dependent

ii. Assistance with eating at home?
☐ Independent ☐ Needed some help ☐ Dependent

iii. Assistance with indoor mobility at home?
☐ Independent ☐ Needed some help ☐ Dependent

iv. Assistance with bathing and dressing and grooming at home?
☐ Independent ☐ Needed some help ☐ Dependent

v. Medication preparation or setup?
☐ Independent ☐ Needed some help ☐ Dependent

vi. Household shopping?
☐ Independent ☐ Needed some help ☐ Dependent

vii. Housework?
☐ Independent ☐ Needed some help ☐ Dependent

d. Do you have stairs at home? ☐ Yes ☐ No

i. Number of stairs to get into house: _____

ii. Number of stairs needed to navigate within the house? (i.e., access to bathroom and shower requires stairs) _____

iii. How much assistance do you need with stairs at home?
☐ Independent ☐ Needed some help ☐ Dependent

iv. What is your preferred time to go to bed? _____

v. What is your preferred bedtime routine:
Describe: _____
_____
_____

4. Have you fallen in the past 6 months? ☐ Yes ☐ No

a. Can you please tell us more?

i. Number of fall(s)?
Describe: _____

ii. Date of fall(s)?
Describe: _____

iii. Location of fall(s)?
Describe: _____

iv. What are your concerns about falling or getting injured while you are here?
Describe: _____

5. What activities, hobbies, and/or social events did you enjoy prior to your current illness/injury? Describe:

a. Are any of these activities, hobbies, and/or social events important for you to continue while at the facility?
Describe: _____
_____

6. Do you have any issues or concerns with your skin?

a. What is your goal related to your skin integrity?
Describe: _____
_____

7. Do you have any food preferences? Describe:

a. Prior to this current illness, did you have any food restrictions, food intolerances, or food allergies?

Describe: _____

b. What is your dietary/nutritional goal while in the facility?

Describe: _____

c. What is your preferred breakfast time and meal?

Describe: _____

d. What is your preferred lunch time and meal?

Describe: _____

e. What is your preferred dinner/supper time and meal?

Describe: _____

8. Do you have any concerns about pain? Describe:

a. What are your goals related to pain?

Describe: _____

9. Tell us what else we need to know to take care of you while you are here?

Describe: _____

_____

_____

_____

_____

_____

_____

_____

_____

10. What can we do to make your stay more comfortable?

Describe: _____

_____

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