



- ST. JOSEPH MERCY HOSPITAL
- SAINT JOSEPH MERCY SALINE HOSPITAL
- SAINT JOSEPH MERCY LIVINGSTON HOSPITAL

**Relationship Centered Care
Adult Admission Assessment**

Please complete pages 1-3. Thank You.

Why are you being admitted to the hospital? _____

What name would you like to be called? _____ What is your occupation? _____

Primary contacts who may receive telephone information about your condition:

1. Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

2. Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Could you be pregnant? Yes No Don't Know NA Enter in PCIS

Are you currently breastfeeding? Yes No NA If yes, enter in PCIS

Please list ALL Prescription Medications you are presently taking including dose and frequency.

Medication (Generic)	Dose	Times per day	Date of Last Dose	Medication (Generic)	Dose	Times per day	Date of Last Dose
1				7			
2				8			
3				9			
4				10			
5				11			
6				12			

Do you have any implanted devices (i.e. Intermittent Cardiac Defibrillator (ICD), Med Port, Insulin Pump) If yes, enter in PCIS

No Yes Please List: _____

Are you or have you been exposed to latex or rubber products on a regular basis? No Yes If yes, initiate latex screening tool

Are you allergic to:

	Yes	No	Reaction
Iodine			
Latex rubber			
Any food			
Adhesive tape			
Other			If YES, list below with reactions:
1.	/		2. / 3. /
Any medications			If YES, list medications and reactions below (drug name / reaction):
1.	/		3. / 5. /
2.	/		4. / 6. /

See Surgery Patient Questionnaire

Do you take any over-the-counter non-prescription medications (i.e. holistic products, herbal medications, dietary supplements, aspirin or other pain reliever, iron, antacids, laxatives, vitamins, etc.) Yes No

Medication	Dose	Times per day	Date of Last Dose	Medication	Dose	Times per day	Date of Last Dose
1				3			
2				4			

Patient Information: Please continue completing this page		Yes	No	To be completed by RN: All 'Yes' responses require F/U or additional info
Communication	Do you need an interpreter if English is not your primary language? Language _____ Who can interpret? _____			Phone number: _____ Interpreter requested <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any pain? If yes, on a scale of 0-10, check the corresponding number of your pain: None Mild Moderate Severe Pain at present: 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 Describe your pain and its location: How do you handle pain at home? What makes it better / worse? Do you take any medications for pain? Please list all: _____			Location: _____ Intensity Rating: _____ Describe character/duration/onset: _____ Pain brochure provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Pain & Comfort	In the last week, has your ability to bathe, dress and do household activities been affected by more than general fatigue?			Describe: Morse Fall Scale: _____ <input type="checkbox"/> Entered in PCIS <input type="checkbox"/> NA Braden Score: _____ <input type="checkbox"/> Entered in PCIS <input type="checkbox"/> NA Functional Screen: _____ <input type="checkbox"/> Entered in PCIS <input type="checkbox"/> NA
	In the last week, did you have any new problems with balance or walking that made you feel unsafe?			
	In the past week, have you noticed a new problem speaking, reading or understanding others?			
	In the past week, did you have a problem coughing when drinking fluids or new problems swallowing?			
	Do you need to use stairs to enter your home? If yes, how many?			
	Do you use equipment at home (i.e., wheelchair, walker, cane, commode)?			
	Do you currently have any home care services (i.e., visiting nurse, meal service, physical therapy, mental health services, hospice)? List agency: _____			
	Do you have any concerns about your discharge (i.e., prescriptions, insurance or money)?			
Functional	Do you have insurance or enough money to pay for medications or supplies?			
	Has someone agreed to help you at home after discharge? List: _____			
	Are you on a special diet? If yes, please list: _____			
	Do you currently have a feeding tube or intravenous line for nutrition?			
	Did you have an unplanned weight loss of 5 pounds or more within the last month?			
	Have you been eating less than 1/2 of your normal food intake for the past seven days or more?			
	Do you have any non-healing sores or large open wounds?			
	Are there foods that are required or forbidden by your personal beliefs, ethnic customs or personal preference (i.e. vegetarian, Jewish Kosher)?			
Nutrition - Elimination	Do you have problems with constipation or diarrhea?			Food Service Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No Nutrition Screen: <input type="checkbox"/> Entered in PCIS <input type="checkbox"/> NA Consult Wound Care: <input type="checkbox"/> Yes <input type="checkbox"/> NA Last BM: _____ Describe problems: _____
	Do you have problems with urination?			

Patient Information: Please continue completing this page		Yes	No	Completed by RN
Domestic Violence	Within the past year, has someone hit, slapped, kicked, choked or otherwise physically hurt you?			Describe:
	Within the past year, have you been forced to have sexual contact when you did not want to?			Domestic Violence Screen: <input type="checkbox"/> Entered in PCIS <input type="checkbox"/> NA
Immunization	Within the past year, have you been immunized against influenza?			Immunization Screen: <input type="checkbox"/> Entered in PCIS <input type="checkbox"/> NA (Sept. - March)
	Have you been immunized against pneumonia? If yes, when? _____			
Social	Although it is normal to have some anxiety when you come to the hospital, have you recently felt the worry or concern was more than you could handle?			<input type="checkbox"/> Consult to Social Work for anxiety Pt. instructed on smoking policy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Request to physician for nicotine patch: <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking cessation information provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Positive ETOH use 4 or more times per week administer AUDIT AUDIT score 8 or greater: <input type="checkbox"/> Consult Social Work <input type="checkbox"/> Notify physician for orders Alcohol type: _____ Frequency used: _____ Amount used: _____
	If yes, do you take any medications to help you with these feelings?			
	If yes, please list: _____			
	Do you smoke or use any other tobacco products?			
	If yes, will you be uncomfortable without it while in the hospital?			
	If no, did you stop smoking within the past year?			
	Do you use alcohol 4 or more times per week?			
If so, what type? _____ How much? _____				
If yes, will you be uncomfortable without it while in the hospital?				
Spirituality	Do you think of yourself as a spiritual person?			Spiritual Continuum <input type="checkbox"/> Thriving <input type="checkbox"/> Fragile <input type="checkbox"/> Distressing (initiate Pastoral Care Consult) <input type="checkbox"/> Despairing (initiate Pastoral Care Consult) Consult to Pastoral Care: <input type="checkbox"/> Yes <input type="checkbox"/> NA <input type="checkbox"/> Declined
	Do you feel discouraged about your illness?			
	If so, does your faith, spiritual belief or other support system provide enough hope for you to cope with it?			
	Overall, do you feel positive or energetic about your future?			
	Does your faith or spiritual belief seem important to you in relation to your healing?			
Would you like to see a member of hospital clergy?				
Education	Have you completed high school or an equivalent program?			Factors affecting learning <input type="checkbox"/> Trouble Reading <input type="checkbox"/> None <input type="checkbox"/> Cognitive <input type="checkbox"/> Does pt. want family present? <input type="checkbox"/> Physical <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Emotional <input type="checkbox"/> Language <input type="checkbox"/> Culture/Religion Address on Plan of Care
	How do you learn best: <input type="checkbox"/> Reading <input type="checkbox"/> Watching <input type="checkbox"/> Hearing <input type="checkbox"/> Doing			
	What do you need to learn before your discharge:			
Advance Directives	Do you have a living will document?			Advance Directive information entered in PCIS: <input type="checkbox"/> Yes <input type="checkbox"/> No Copy to Chart: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Family to bring copy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Information Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
	If yes, does the document represent your wishes?			
	Do you have a durable power of attorney for health care / advance directive?			
	If yes, does the document represent your wishes?			
	If so, please name Name of DPOA: _____ Relationship: _____ Phone #: (_____) _____			
	Did you bring a copy of your living will or advance directive with you?			
If you do not have an Advance Directive / DPOA for health care, would you like information?				

◆ What is one important thing about you that we need to know? _____

◆ What is most important to you about your care or treatment while you are in the hospital? _____

◆ Based on your ethnic, religious, spiritual or personal background, are there certain practices related to your personal care that we need to know? _____

◆ Have you had recent changes or losses in your life in addition to this illness (i.e. death of spouse or parent, divorce, loss of job)? _____

◆ How can we help you prepare for discharge? _____

Patient / Person completing form: _____ Date & Time: _____

Relationship to patient: _____

PLEASE STOP HERE – THANK YOU FOR COMPLETING THIS FORM

Nursing Staff Only

ADMITTING DATA Admitted to: _____ Arrival Time: _____

Admitted from: OR ED DA

Residence: Home ECF / AFC / Asst. Living Other _____

T _____ (O / R / T / A) P _____ RR _____ BP _____

WT _____ HT _____ Pain Score _____ Admission Orientation Completed: Yes Unable

Completed by: _____ (Assistive Staff) Date / Time: _____

ED DOCUMENTATION REVIEWED AND RECONCILED WITH PATIENT / SIGNIFICANT OTHER Yes No NA

Patient Valuable	Disposition			Patient Valuable	Disposition		
	w/patient at bedside	w/family	Security		w/patient at bedside	w/family	Security
Glasses:				Earrings:			
Contact Lenses:				Watch:			
Hearing Aide(s) (circle): Right Left				Bracelet:			
Dentures (circle): Upper Lower Full Partial				Wallet / Purse:			
Ring(s):				Cash: \$ _____			
Necklace:				Clothing / Shoes:			
				Equipment (circle): Cane Walker Prosthesis			
				Other:			

PLEASE ENCOURAGE PATIENTS / FAMILIES TO TAKE ALL ITEMS OF VALUE HOME!

RN _____ Date & Time _____

RN _____ Date & Time _____

Patient / Representative unable to complete.

1669415667

Provider #
1972725758

KS BCN

Provider Rep / Prov. Affairs
866-299-4667
- referrals / homebase
recourse / agreement
change form

Referral Request for Group ID Changes

* required fields

Access to e-referrals (I-Exchange)

Access to e-referrals (I-Exchange), either now or in the future, for both my individual

and the following users to my existing e-referral

*Practice name: Michigan Multispecialty Physicians

Current user web-DENIS ID
p123109

Name

Watson

*Please add delete (select one) the following providers to my existing e-referral.

*I-Exchange ID#: 1669415667

Provider name (print first and last name)

*10-digit NPI

Sean

McLaughlin

1669415667

I hereby state that the information on this request is correct and the provider codes listed pertain to my practice/facility.

Kathy Watson

2/24/11

*Provider/facility representative name

Date

Surgery Coordinator

38-3461163

Title of representative above

*Tax ID number

734-712-8130

734-712-8111

watsokaa@trinity-health.org

*Telephone number

Fax number

E-mail address

Note: If the name above contractually represents multiple providers/codes in the business of health insurance billing/inquiry, they must include a print out of all such codes with this agreement.

Use the submit button to send the completed form electronically to the BCN Provider Affairs office. The submit feature requires an installed e-mail application. Alternately, you may save the completed form locally and e-mail it as an attachment to EastRPA@bcbsm.com or fax the completed form to 810-720-8627.

Contact BCN Provider Affairs if you have questions.

This box for BCN use only.

The data on this form will be loaded by BCBSM as represented. MCO representative signing below verifies accuracy of data.

BCN provider representative