Universal Initial Interview Flow Chart

Wayne HealthCare 835 Sweitzer Street • Greenville, Ohio 45331

Chief Complaint/Procedure: ____

Received From: ☐ Admitting ☐ ED ☐ Physician's Office ☐ Extended Care Facility ☐ Home

Method of Arrival: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Carried

Admission Status: ____

Is Patient Assigned To Observation Status? ☐ Yes ☐ No (If Yes, Answer Following Two Questions)
Was The Patient Given Observation Status Brochure? ☐ Yes ☐ No
Was The Patient Informed Of Possible Limited Insurance Coverage And Patient Responsibility? ☐ Yes ☐ No

Has Patient Been Admitted in the Last 30 Days ☐ Yes ☐ No (if yes, complete Readmit Interview)

Who Was This Information Obtained From? ☐ Patient ☐ Spouse ☐ Parent
☐ Other: ______________________

Emergency Contact (Important Phone Numbers):
Name: ____________________________________ Phone: ______________
Name: ____________________________________ Phone: ______________

Would You Like To Establish A HIPAA Password?
☐ Yes ______________________________ ☐ No (If No, Info Will Be Given Out Over the Phone)

Advance Directives:
☐ Durable Power Of Attorney For Health Care ☐ Living Will ☐ On File ☐ Requests Info
☐ Declines Information

Patient Height: ______________ **Patient Weight**: ______________

What Are The Patient Expectations? ______________________________________

Do you take any Medications? (Include Herbal Medicines, Vitamins, Minerals, Over The Counter Medications & Supplements, Birth Control Pills, Chemotherapy) ☐ Yes ☐ No If Yes, Please List

Name Of Medication	Dose	How Often?	Reason	Last Dose Taken	Name Of Medication	Dose	How Often?	Reason	Last Dose Taken

Does The Patient Smoke? ☐ Yes, Current _____ Per Day X _____ Years ☐ No

Has The Patient Ever Smoked? ☐ Yes ☐ No
If Yes, List History: _____ Packs Per Day X _____ Years Patient Quit _____ Years Ago

Patient Instructed Not To Smoke Day Of Surgery? ☐ Yes ☐ No

Patient Name: ______________________
DOB: ______________________
Patient Account #:______________________
Patient Label

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Do You Have Any Allergies (Medications, Environment, Or Foods)? ☐ No Known Allergies ☐ Allergies, Please List:

Substance	Reaction	Substance	Reaction

Family Practice Physician: ______________________________

Specialists: ______________________________

Food Dislikes: ☐ None ☐ Eggs ☐ Chicken ☐ Milk ☐ Fish ☐ Other

Alcohol Use/Drug Use: ☐ Denies or None ☐ Beer _____ # Daily ☐ Marijuana ☐ Wine _____ # Daily ☐ Cocaine

Patient Was Not Assessed d/t: ☐ Lives at an Extended Care Facility ☐ Pregnant on Admission ☐ Hospice ☐ Not a Diabetic

Type of Diabetes: ☐ The Patient was Recently Diagnosed ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other:_____________
☐ Do Not Know ☐ Patient has A1C Checked in the Last 6 Months ☐ Yes ☐ No ☐ Unsure
☐ Healthy Eating ☐ Patient Follows a Diet at Home

Being Active: ☐ Patient Exercises or Is Active ☐ Yes ☐ No

Monitoring: ☐ The Patient Monitors Blood Sugars ☐ Yes ☐ No
☐ Patient Tests Blood Sugar ____ x a day ☐ Patient Needs a New Meter

Medications for Diabetes: ☐ Insulin ☐ Oral ☐ Patient Takes Diabetes Medications as Prescribed
☐ Patient is Unable to Afford the Medication
☐ Patient is Unable to Tolerate Medication

Problem Solving: ☐ Patient Knows What to do When Blood Sugar is High ☐ Patient Has a Plan for Sick Days
☐ Patient Knows How to Recognize and Treat Low Blood Sugar

Reducing Risk: ☐ Patient Able to Afford Diabetes Supplies ☐ Yes ☐ No ☐ Patient Does Daily Foot Exams
☐ Patient has a Yearly Eye Exam

Cardiac/Heart Hx: ☐ None ☐ Ablation ☐ Arrhythmia ☐ CABG _____# Vessels ☐ Chest Pain/Angina ☐ CHF
☐ Heart Attack ☐ High Cholesterol/Triglycerides ☐ HTN ☐ Hypotension ☐ Murmur/Valve Problems
☐ Pacemaker ☐ Palpitations ☐ Angioplasty/Cath

Breathing/Respiratory History: ☐ None ☐ Pulmonary Embolism ☐ Asthma ☐ Bronchitis ☐ COPD
☐ Emphysema ☐ Chronic Cough ☐ Tuberculosis ☐ Pneumonia ☐ Sleep Apnea
☐ Other ____________________

Endocrine History: ☐ None ☐ Arthritis ☐ Thyroid Problems ☐ Lupus ☐ Insulin Pump ☐ NIDDM ☐ IDDM
Blood Disorders: ☐ Anemia ☐ Leukemia ☐ Clotting/DVT Problems ☐ Hemorrhage ☐ Phlebitis

Neuro/Psychological History: ☐ None ☐ Strokes ☐ Sleep Problems ☐ Mental Illness ☐ Depression ☐ Anxiety
☐ Seizures ☐ Cancer ☐ Alzheimer's ☐ Dementia ☐ Parkinson's ☐ Schizophrenia

Gastrointestinal History: ☐ None ☐ Diverticulitis ☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis
☐ Crohn's Disease ☐ Hepatitis Type: _____ ☐ Constipation ☐ Heartburn/Indigestion ☐ Reflux
☐ Hiatal Hernia ☐ Ulcer ☐ Liver Problems: ______________________________

Renal/Reproductive History: ☐ None ☐ Kidney Stones ☐ Bladder Stones ☐ Kidney Infections
☐ Bladder Infections ☐ Prostate ☐ Sexually Transmitted Disease ☐ Last Period: __________ ☐ Pregnancies
☐ Abortions

Safety in the Environment: ☐ Yes ☐ No Information: ______________________________
____
____

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Permanent Radiation Implants (e.g. Prostate Seeds): ☐ Yes ☐ No **If Yes, Call RSO at 5131 ASAP**

Surgical History: ☐ Denies ☐ Appendectomy ☐ Carpal Tunnel ☐ Cysto ☐ D & C ☐ Ear Tubes
☐ Gallbladder ☐ Hernia ☐ Hysterectomy ☐ Knee Replacement ☐ Tonsils ☐ Tubal Ligation
☐ Other ______________________ ☐ Other ______________________

Previous Problems With Anesthesia: ☐ No ☐ Yes If Yes, Describe ______________________

Family History Of Anesthesia Problems: ☐ No ☐ Yes If Yes, Describe ______________________

Family History: ☐ None ☐ Heart Problems ☐ Respiratory/Breathing Problems ☐ Diabetes ☐ Cancer
☐ Other ______________

X-Ray History: Contrast/Dye Past 48 Hours? ☐ Yes ☐ No
Use Of: ☐ Glucophage ☐ Avandamet ☐ Glucovance ☐ Metaglip ☐ Metformin

Vaccination Status: Influenza ☐ No ☐ Yes Date:____________ Pneumococcal ☐ No ☐ Yes Date:__________ ☐ Refused
☐ Vaccinated within < 5 yrs. ☐ < 1 yr. ☐ Does Not Meet Criteria per Order Sheet

Pap Smear Testing: ☐ Yes, Patient Request Pap Smear During Stay ☐ No, Patient Refuses Pap Smear During Stay

Patient Valuables: ☐ Not Applicable ☐ No Medications Brought With Patient ☐ Home Medications Sent To Pharmacy
☐ Home Medications Sent With Family ☐ Billfold ☐ Money ☐ Purse ☐ Glasses ☐ Contacts
☐ Hearing Aids ☐ Prosthesis ☐ Jewelry ☐Religious Items ☐ Dentures (☐ Upper ☐ Lower)
☐ Cell Phone ☐ Lap Top ☐ Clothing
☐ Other: ____

☐ Kept In Room ☐ Sent Home ☐ Hospital Safe ☐ Family Not Present

Patient Rights: ☐ Information Not Available At This Time ☐ Patient Informed Of Rights and Responsibilities
☐ Available At Bedside for Review ☐ Viewed Guide to Patient And Family Services
☐ Pre Op Call Not Applicable

Religious Beliefs: ☐ No ☐ Yes: ______________________
☐ Religion/Cultural Beliefs Affecting Care: ____
☐ Clergy To Notify: ______________________ ☐ Church: ______________________ ☐ Hospital Chaplain

Knowledge Base/Highest Grade Completed: ______________________ ☐ Primary Language______________________
☐ Cognitive Barrier _________________ Learns Best By: ____
☐ Reading Difficulties ______________________ Communication Barrier: __________________________________
☐ Readiness to Learn

Functional Screening: ☐ None ☐ Drinking ☐ Meal Preparation ☐ Feeding ☐ Bathing ☐ Dressing
☐ Toileting ☐ Bed Mobility ☐ Transferring ☐ Ambulating ☐ Stair Climbing ☐ Grooming

Current Assistance/Support: ☐ Independent ☐ Non-Ambulatory ☐ Hospice
☐ Nursing Home: ______________________ ☐ Home Health: ______________________

Present Living Condition: ☐ Home With Family ☐ Home Alone ☐ Homeless ☐ Single Level Home
☐ Multi Level with Stairs ☐ Outside Steps ☐ Homeless

Primary Care Giver: ☐ Self ☐ Spouse/SO ☐ Parent ☐ Son ☐ Daughter ☐ Friend ☐ Neighbor
☐ Extended Care Facility ☐ Other: ______________________

Intended Destination Post Discharge: ☐ Home (☐ Alone ☐ Family) ☐ Undetermined ☐ Nursing Home
☐ Rehab Facility ☐ Hospice

Home Equipment: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Oxygen @ L _____ /M ☐ CPAP ☐ Nebulizer
☐ Hospital Bed ☐ Crutches Company that Provides Home Health Equipment: ______________________

Education Needs: ☐ Medication ☐ Food/Drug Interactions ☐ Medical Equipment
☐ Infection Control Pamphlet Provided ☐ Mobility
☐ Wound Management ☐ Pain Management ☐ Nutrition
☐ Bowel/Bladder Management ☐ Self Care ☐ Other: ______________

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Factors Influencing Learning Needs/Readiness to Learn: ☐ Exhibits Appropriate Learning Skills ☐ Acceptance
☐ Non Accepting ☐ Depression ☐ Anxiety ☐ Irritability ☐ Labile ☐ Vision Problems
☐ Hearing Problems ☐ Speech Deficit ☐ Confused ☐ Eager

Referrals: ☐ Social Worker ☐ Nursing Home ☐ Home Health ☐ Hospice ☐ Enterostomal Nurse ☐ Dietitian
☐ Rehab Services ☐ Meals On Wheels

Pharmacy of Choice: ____

Pre-Op Call: ☐ Instructions About AM Medications ☐ Bring Home Medications ☐ NPO Status Clear Liquids______
☐ Loose Comfortable Clothing ☐ Bathe And Shampoo ☐ No Contact Lens
☐ No Cosmetics, Lotions, Powders, Body Piercings Or Nail Polish ☐ No Valuables, Jewelry, Or Money
☐ Do You Know How To Get Here And Register?
☐ Have A Responsible Adult Drive You Home And Stay With You For 24 Hours Arrival Time______________
☐ Patient/Family Verbalized Understanding to Arrive on Surgical Unit on: Date:_____________Time:________

Validation: ☐ Agree With Initial Doc Charted ☐ Agree With Initial Doc, Except: ___________________________
☐ Information Reviewed ☐ Documentation Reviewed

Nursing Notes: ____
____

Reviewed by: Nurse Signature: ______________________________

Date: ______________ **Time**: ______________

Patient Name: ______________________
DOB: ______________________
Patient Account #:______________________
Patient Label