parkview MEDICAL CENTER

Wound Care

PATIENT HISTORY AND ASSESSMENT – O S T O M Y

Primary Care Physician: _____ **Referring Physician:** _____
Pharmacy: _____ **Home Health:** _____
Allergies (list food, tape, medication , latex) _____
_____

Please list all medications including over the counter medicine, (i.e., inhalers, pain relievers, herbs etc) and dosages.

MEDICATION/DOSAGES	MEDICATION/DOSAGES

Please list any medical conditions you have had in the past.

Please list any surgeries you have had and the dates

Type of ostomy?
Why do you have an ostomy
Who was the surgeon that performed the ostomy surgery?
What pouching system are you using?
Do you need assistance with self-care { } No { } Yes Describe
Are there spiritual or cultural preferences that affect your care?
Are you able to walk, get in and out of a bed/chair by yourself? { } Yes { } No Describe:
Are there any problems in your environment that need to be addressed? { } No { } Yes Describe:
Will you need someone to assist you with your ostomy care: { } No { } Yes Describe:
Describe your present attitude regarding dealing with your ostomy care?

Patient Label

PAIN INTENSITY SCALE Rate Pain None 1 2 3 4 5 6 7 8 9 10		
RATE PAIN:	Current pain level_____ Worst Pain Level_____ Least Pain Level_____	
PATIENT LOCATION (indicate on diagram(s) below where patient indicates pain location)		
PATIENT STATEMENT DESCRIBING PAIN		
ONSET OF PAIN:		

PRESENT PAIN MANAGEMENT REGIMEN		
Medication/treatment	**Effective**	
	YES	NO
	YES	NO
	YES	NO

PAST PAIN MANAGEMENT REGIMEM		
Medication/treatment	**Effective**	
	YES	NO
	YES	NO
	YES	NO

HOW DOES THE PAIN IMPACT DAILY LIFE
IDENTIFY PATIENT GOALS FOR PAIN MANAGEMENT None 1 2 3 4 5 6 7 8 9 10 Other_____
Other pain refer to primary care provider for management plan ☐

Patient Label

NUTRITIONAL SCREENNG TOOL

DATE:_____ HEIGHT:_____ WEIGHT_____ ☐ Male ☐ Female

Current Diet:_____

ASSESSMENT QUESTIONS	YES
1. I have an illness or condition that made me change the kind and/or amount of food I eat	2
2. I eat fewer than 2 meals per day.	3
3. I eat few fruits or vegetables, or milk products	2
4. I have 3 or more drinks of beer, liquor or wine almost every day	2
5. I have tooth or mouth problems that make it hard for me to eat.	2
6. I do not always have enough money to buy food.	4
7. I eat alone most of the time.	1
8. I take one or more different prescribed or over-the-counter drugs per day.	1
9. Without wanting to I have lost or gained 10 pounds in the last 6 months.	2
10. I am not always physically able to shop, cook, and/or feed myself.	2
TOTAL	

Pat Cat	Yes Total	Risk Level	Plan of care
	0-2	Low Nutritional Risk	Re-evaluate in 8 weeks. Indicate ICMG to review during 8 week healing assessment.
	3-5	Moderate Risk	Educate the patient/family/caregiver to improve eating habits and life-styles. This may include consideration to patient's food preference and frequency of meals. Involve the Nutritionist/Physician as needed for educational materials or suggestion in improvement measures.
	6 or more	High Nutritional Risk	Nutritional consult indicated. Inform physician for further assessment/orders. Documentation on patient chart required.

Comments:

_____ _____

Signature of patient or family member completing form Date and Time

_____ _____

Signature of Staff reviewing Date and Time

Patient Label