DATE:	TIME:

NUTRITION RISK SCREEN: *Circle the number in the "Yes" column for those that apply to the patient.*	**Yes**
Total nutritional score at the bottom. Patient assessed initially and at least every three months. ***(Nurse to frame these as questions to patient)***	
I have an illness or condition that made me change the kind and/or amount of food I eat	2
I eat fewer than two meals per day	3
I eat few fruits and vegetables, or milk products	2
I have three or more drinks of beer, liquor or wine almost every day	2
I have tooth or mouth problems that make it hard for me to eat	2
I don't always have enough money to buy the food I need	4
I eat alone most of the time	1
I take three or more different prescribed or over-the-counter drugs a day	1
Without wanting to, I have lost or gained 10 pounds in the last six months	2
I am not always physically able to shop, cook and/or feed myself	2
This tool was developed and distributed by the Nutritional Screening Initiative, a project of: American Academy of Family Physicians, The American Dietetic Association, National Council on the Aging, Inc. 2004; Retrieved on line July, 2013 **Total**	

Circle the risk level below and follow appropriate interventions for risk level. Interventions documented in care plan

0-2 = Good Risk	3-5 = Moderate Risk	6 or higher = High Risk
No interventions needed	☐ Provide education on nutrition ☐ Provide education on elevated blood sugars and impact on wound healing, as applicable	☐ Provide education on nutrition ☐ Provide education on elevated blood sugars and impact on wound healing, as applicable ☐ Obtain physician order for referral of patient for further nutrition evaluation

ABUSE/SUICIDE RISK SCREEN: *Check the appropriate answer for each question. (Nurse to ask patient questions 1-4 when patient is alone.)*		
1. Has anyone close to you tried to hurt or harm you recently?	☐ Yes	☐ No
2. Do you feel uncomfortable with anyone in your family?	☐ Yes	☐ No
3. Has anyone forced you to do things that you didn't want to do?	☐ Yes	☐ No
4. Do you have any thoughts of harming yourself?	☐ Yes	☐ No
5. Patient displays signs or symptoms of abuse and/or neglect.	☐ Yes	☐ No
If yes to any of the above questions, explain:		
If yes to any of the above questions, you also must: ☐ Notify the Wound Care Physician Date_____and Time _____Notified ☐ Make a referral to Social Services Date_____and Time _____Notified		

FALLS RISK SCREEN: *Circle the appropriate score for each question. Total the score at the bottom of this section.*	
1. History of falling - immediate or within 3 months	25
2. Secondary diagnosis	15
3. Ambulatory aid	
None/bed rest/wheelchair/nurse	0
Crutches/cane/walker	15
Furniture	30
4. IV Access/Saline Lock	20
5. Gait/Transferring	
Normal/bed rest/immobile	0
Weak	10
Impaired	20
6. Mental status	
Oriented to own ability	0
Overestimates or forgets limitations	15
National Center for Patient Safety.(2009). Retrieved online July 2012: http://www.patientsafety.gov/CogAids/FallPrevention/index.html#page=page-1 **Total:**	

Fall Risk Scale and Risk Level (Interventions are documented in the care plan)

0– 24 - Low Risk	25–50 - Medium Risk	51 and higher - High Risk

Nurse Signature : _____Date: _____Time: _____

Portneuf MEDICAL CENTER

INITIAL RISK AND EDUCATION ASSESSMENT

DOC NO WC00022 (06/29/16) AR

PATIENT LABEL

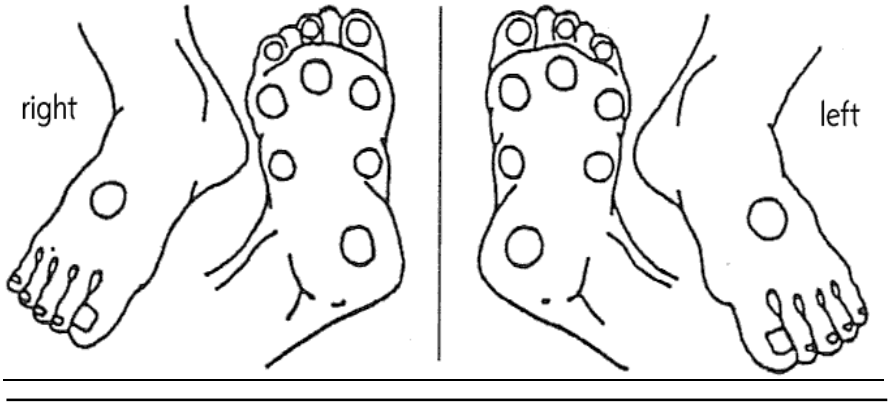
Do Not Place Below This Line.

DATE:	TIME:

NEUROPATHY ASSESSMENT

☐ Unable to perform due to altered mental status
☐ Unable to perform foot assessment due to amputation ☐ Right ☐ Left

+ = Sensation present **--** = Sensation absent



VASCULAR ASSESSMENT		
	RIGHT	**LEFT**
Ankle Brachial Index (ABI)		
Toe Brachial Index (TBI) – *If applicable*		

FOOT ASSESSMENT		
	RIGHT ☐ **Not Applicable** ☐ **Not Assessed**	**LEFT** ☐ **Not Applicable** ☐ **Not Assessed**
Other Deformity	☐ Yes ☐ No	☐ Yes ☐ No
Prior Foot Ulcer	☐ Yes ☐ No	☐ Yes ☐ No
Charcot Joint	☐ Yes ☐ No	☐ Yes ☐ No
Prior Amputation	☐ Yes ☐ No	☐ Yes ☐ No

TOE NAIL ASSESSMENT		
	RIGHT ☐ **Not Applicable** ☐ **Not Assessed**	**LEFT** ☐ **Not Applicable** ☐ **Not Assessed**
Thick	☐ Yes ☐ No	☐ Yes ☐ No
Discolored	☐ Yes ☐ No	☐ Yes ☐ No
Deformed	☐ Yes ☐ No	☐ Yes ☐ No
Improper Length and Hygiene:	☐ Yes ☐ No	☐ Yes ☐ No

NOTES

Nurse Signature: _____ **Date:** _____ **Time:** _____

Portneuf MEDICAL CENTER

INITIAL RISK AND EDUCATION ASSESSMENT

DOC NO WC00022 (06/29/16) AR

PATIENT LABEL

Do Not Place Below This Line.

DATE:	TIME:

PAIN ASSESSMENT

Pain present now? □ Yes □ No - If NO, skip rest of this section. □ Non-wound related pain referred to primary care provider

With Dressing Changes: □ Yes □ No Location of pain:

Current Pain Level: □ Insensate 0 1 2 3 4 5 6 7 8 9 10 **Duration of Pain**: □ Constant □ Intermittent

Character of Pain: □ Aching □ Burning □ Cramping □ Difficult to pinpoint □ Dull □ Easy to pinpoint □ Exhausting □ Heavy □ Sharp □ Shooting □ Splitting □ Stabbing □ Tender □ Throbbing □ Tiring □ Other:

Pain Management: □ Medication □ Rest □ Activity □ Heat Application □ Cold Application □ Massage □ T.E.N.S □ Leg Drop or Elevation □ Other

Is Current Pain Management Adequate? □ Adequate □ Inadequate

Patient's Stated Goals for Pain Management: **Modification to Pain Management:**

WOUND IMPACT ON ACTIVITIES OF DAILY LIVING

Dressing/Bathing	□ Yes	□ No	Hygiene	□ Yes	□ No	Housekeeping	□ Yes	□ No
Eating	□ Yes	□ No	Ability to use phone	□ Yes	□ No	Laundry	□ Yes	□ No
Ambulating	□ Yes	□ No	Shopping	□ Yes	□ No	Handle medications	□ Yes	□ No
Toileting	□ Yes	□ No	Food Preparation	□ Yes	□ No	Handle money	□ Yes	□ No

EDUCATION ASSSESSMENT

□ Patient assessed OR □ Caregiver assessed – Name of Caregiver:_____

Patient not assessed, provide reason:

Educational assessment below is of the individual noted above.

Learning Preference: □ Explanation □ Demonstration □ Video □ Communication Board □ Printed Material

Highest Education Level: □ College or Above □ High School □ Grade School

Primary Language: □ English □ Spanish □ Other:

Preferred Language for Healthcare Information: □ English □ Spanish □ Other:

Language Barrier:	Translator Needed?	
□ No □ Yes*	□ No □ Yes	□ Hospital Employed Language Interpreter □ Contract Interpreting Service □ Trained Bi-Lingual Staff

Memory Deficit:	Emotional Barrier:	Cultural/Religious Beliefs that would impact wound care - e.g. use of blood, porcine (pig) or bovine (cow) based tissue products
□ No □ Yes*	□ No □ Yes*	□ No □ Yes*

Impaired Vision: □ No □ Glasses □ Contacts □ Legally Blind Impaired Hearing: □ No □ Complete Loss □ Hearing Aid

Decreased Hand Dexterity: □ No □ Limitations

Knowledge Level of Health Problem: □ High □ Medium □ Low

Comprehension Level (Ability to Understand Concepts): □ High □ Medium □ Low

Ability to understand written instructions: □ High □ Medium □ Low

Ability to understand verbal instructions: □ High □ Medium □ Low

SELF HEALTH MANAGEMENT ASSSESSMENT

Willingness to engage in self-management activities: □ High □ Medium □ Low

Readiness to engage in self-management activities: □ High □ Medium □ Low

Anxiety Level: □ Calm □ Anxious	Cooperation: □ Cooperative □ Uncooperative
Perception: □ Coherent □ Confused	Interest in Health Problem: □ Asks Questions □ Uninterested

Education Importance: □ Acknowledges Need □ Denies Need

OTHER: Does Patient smoke tobacco or other substances? □ Yes □ No Is Patient diabetic? □ Yes □ No

NURSE'S NOTES

Nurse Signature : _____ Date: _____ Time: _____

INITIAL PATIENT ASSESSMENT – C313F – Page 2 of 2
REVISED (1/2016)

Portneuf MEDICAL CENTER

INITIAL RISK AND EDUCATION ASSESSMENT

DOC NO WC00022 (06/29/16) AR

PATIENT LABEL

Do Not Place Below This Line.