

Service User ID label :

PHYSICAL HEALTH ASSESSMENT ON ADMISSION

PHYSICAL OBSERVATIONS (To be completed by admitting doctor or nurse):

Height: _____ m Blood Pressure: _____ Resp. Rate: _____ resp/min
 Weight: _____ kg Heart Rate: _____ bpm Blood Sugar (if relevant) _____
 BMI: _____ Temperature: _____ °C Urinalysis: _____
 Waist: _____ cm Oxygen Saturation: _____ % HCG: _____

Drug Screen:

Name (Print): _____ Signed: _____

Discipline: _____ Professional Register No: _____ Date: _____

THIS SECTION TO BE COMPLETED BY ADMITTING/TREATING DOCTOR: PHYSICAL EXAMINATION (Can also be completed by appropriately trained Advanced Nurse Practitioner (ANP))

Consent: Service user declined. Allergies: _____

Verbal consent obtained. Vaccinations (if relevant): _____

Chaperone: Chaperone used (same gender as service user)

RESPIRATORY:

(tick all that apply)



- Chest Clear
- Equal Air Entry
- No Wheeze
- No crepitations
- Other: _____

CARDIOVASCULAR:

(tick all that apply)

- Warm & Peripherally well perfused
- Normal Sinus Rhythm
- Normal Heart Sounds
- Other: _____

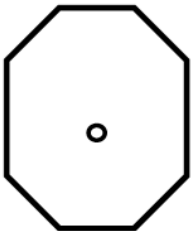
ECG:

(tick all that apply)

- Declined / Unable to Answer
- Not needed
- Day team to do
- Done. Results: _____

ABDOMEN:

(tick all that apply)



- Soft, non-tender
- No guarding
- No organomegaly
- Normal bowel sounds
- Other: _____

NEUROLOGICAL:

(tick all that apply)

- Cranial Nerves Intact
- Power 5/5 throughout upper & lower limbs
- Normal reflexes
- Normal sensation
- Other/Comments: _____

GENERAL/OTHER CONSIDERATIONS:

(tick all that apply)

- Anaemia Yes No
- Jaundice Yes No
- Cyanosis Yes No
- Oedema Yes No
- Thyroid exam Yes No
- Gynecomastia Yes No
- Needs prophylaxis for Venous Thrombosis Yes No
- Calves - evidence of DVT Yes No

Comments: Other physical health issues identified please list

Service User ID label :

PHLEBOTOMY: (tick all that apply)

- Declined Unable to Answer Bloods ordered

Samples taken

- | | | |
|--------------------------------|--|------------------------------------|
| <input type="checkbox"/> FBC | <input type="checkbox"/> Lipid Profile | <input type="checkbox"/> HBA1C |
| <input type="checkbox"/> U&E's | <input type="checkbox"/> Fasting Glucose | <input type="checkbox"/> Prolactin |
| <input type="checkbox"/> CRP | <input type="checkbox"/> B12 | <input type="checkbox"/> Others: |
| <input type="checkbox"/> LFT's | <input type="checkbox"/> Folate | |
| <input type="checkbox"/> TFT's | <input type="checkbox"/> Vit D | |

Any Relevant Medical History (especially diabetes or cardiovascular) _____

Any Relevant Family Medical History: _____

How would you describe your physical health? _____

Do you wish to tell me about any physical problems including any pain you may be experiencing? _____

Have you lost or gained any weight recently? Yes No

If yes was it planned? Yes No

Please explain: (Give details including how much over what time period and advise team to carry out nutritional screening/refer to Dietitian as available)

Have you had any concerns regarding: Change to your appetite Swallowing Feeling of choking on food and drinks

Coughing during or after a meal Problems chewing food A number of recent chest infections

Details: _____

(If required please indicate referral to Dietitian and/or Speech & Language Therapist (SLT) team as available)

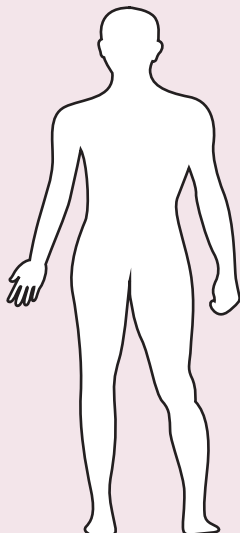
Service User Declined to answer Service user unable to answer box Not clinically appropriate at this time

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

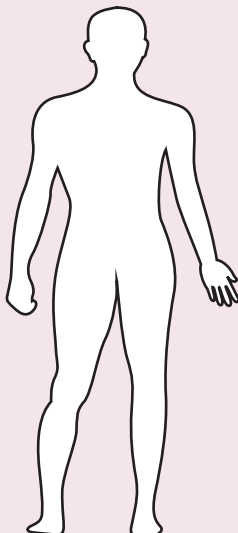
If the answer is never, reinforce abstinence. Any positive result requires further assessment using DUDIT screening tool.

Please mark on diagram any abnormalities, areas of bruising, skin cyanosis, skin condition including pressure sores, wounds, rashes, puncture marks, and self harm, OR please tick (✓) if no abnormalities detected

FRONT



BACK



General Appearance:

Name of Doctor (Print):

Signed: _____

MCRN No: _____

Date: _____

Service User ID label :

LIFESTYLE ASSESSMENT

The following section is to be completed by any member of the Treating Multidisciplinary Team within 7 Days of Admission if appropriate. If any of these issues are brought up during the initial assessment please fill in and record as appropriate.

All relevant information from this Physical Health Assessment form to be included in the service users Individual Care Plan (ICP)

National Screening Programme

National Screening Programme (NSP) as per eligibility criteria. (Please circulate eligible programmes)

Bowel Screen (adults aged 60-69yrs)

Breast Check (women aged 50-69 yrs)

Cervical Check (women aged 25-60 yrs)

Diabetic Retinal Screening (Type 1 & Type 2 diabetics 12yrs and over)

Has service user attended relevant screening programmes? Yes No _____

GIVEN brief advice / brief intervention on screening programmes and made aware of the **Free-phone 1800 454 555** to check if they are on the relevant Screening Programmes' register? Yes No

GP/Dental/Optical Assessment

General Practitioner Contact: *Please Circle* Regular Infrequent Rarely

Dental Practitioner Contact: *Please Circle* Regular Infrequent Rarely

Does service user have any dental problem? Yes No Declined Unable to Answer

Dentures: Any issues with dentures Yes No Declined Unable to Answer

Obvious caries: Advice given re dental care Yes No Declined Unable to Answer

Painful teeth/Gums: Advised to attend Dentist Yes No Declined Unable to Answer

Does service user have any problems with eyesight? Yes No Declined Unable to Answer

Glasses: Any issues with glasses Yes No Declined Unable to Answer

Referred to opticians: Yes No Declined Unable to Answer

Does service user have any problems with hearing? Yes No Declined Unable to Answer

Hearing aid : Any issues with hearing aids Yes No Declined Unable to Answer

Referred to Audiologist: Yes No Declined Unable to Answer

Sexual Health and Sleep Patterns

SLEEP AND SEXUAL HEALTH

Is service user sexually active? Yes No

Is service user or could they be pregnant? Yes No *If yes, consider referral to Perinatal Mental Health Services.*

Do they have any concerns in relation to their sexual health?

(If required and if clinically appropriate please indicate referral to sexual health services as available)

GIVEN brief advice / brief intervention on safer sex and/or contraceptive practices

SLEEP

Does service user have any problems with sleep? Yes No Not Asked Declined / Unable to Answer

How many hours did Service User sleep last night? _____

How many hours does Service User usually sleep at night? _____

Does Service User take sleeping tablets? Yes No *If yes please give name/dosage* _____

GIVEN brief advice / brief intervention on sleep hygiene

Date: ____/____/____ **Signature:** _____ **Discipline:** _____

TOBACCO USE

1. Does service user **SMOKE** any tobacco products?

- Daily
- Occasional (Less than daily)
- Quit Smoking (within last 6 months)
- Quit Smoking (longer than 6 months)
- Never
- Service user declined/not interested at this time
- Service user capacity or decision making diminished
- Family member/carer involved

TOBACCO INTERVENTION

If service users does not smoke or has quit longer than 6 months affirm and reinforce benefits of being tobacco free

If service user is a Tobacco User (daily or occasional smoking) or has **QUIT WITHIN THE LAST 6 MONTHS** tick all actions taken **Brief intervention**

(emphasising the benefits of quitting and offering strategies to help quit)

Signposted to HSE Tobacco cessation services /QUIT service (helpline 1800 201 203 and www.quit.ie)

Referred to HSE Tobacco cessation services /QUIT services Prescribed/

Referred for Stop Smoking medication (NRT/Varenicline)

Service user declined/not interested in quitting at this time

Date: ____/____/____ Signature: _____ Discipline: _____

ALCOHOL USE (AUDIT-C TOOL)

1. How **OFTEN** do you have a drink containing alcohol?

- | | Score |
|------------------------|-------|
| Never | 0 |
| Monthly or less | 1 |
| 2-4 times a month | 2 |
| 2-3 times a week | 3 |
| 4 or more times a week | 4 |

2. How **MANY** standard drinks (10 grams) of alcohol do you have on a typical day when drinking?

- | | |
|------------|---|
| 1-2 | 0 |
| 3-4 | 1 |
| 5-6 | 2 |
| 7-9 | 3 |
| 10 or more | 4 |

3. How **OFTEN** do you have 6 or more standard drinks (10 grams each) on a single occasion in the last year?

- | | |
|-----------------------|---|
| Never | 0 |
| Less than monthly | 1 |
| Monthly | 2 |
| Weekly | 3 |
| Daily or almost daily | 4 |

ALCOHOL SCORE

(Add scores from all three questions)

ALCOHOL RISK

Total SCORE 0-4 **LOW RISK**

Total SCORE 5+ **INCREASED RISK**

ALCOHOL INTERVENTION

If service user is assessed as **Low Risk 0-4:** **AFFIRM** and reinforce benefits of remaining at the low risk level.

If service user is assessed as **Increased Risk 5+:**

Engage service user in a brief intervention to discuss the following:

The risks to health of drinking in short and long term

The benefits of cutting down

Strategies for managing drinking pattern

(To assist with this discussion you can refer to "A Quick Question" leaflet https://www.healthpromotion.ie/A_Quick_Question)

Signpost to www.askaboutalcohol.ie

Refer to HSE Drug and Alcohol Helpline Mon-Fri 9.30-5.30 Tel.1800 459 459 for information on local alcohol and drug services

RECOMMEND that service user discuss with GP/Doctor/MDT

Refer to specialist substance misuse service

Service user declined/not interested at this time

Service user capacity or decision making diminished

Family member/carer involved

LOW RISK GUIDELINES

- 11 standard risk or less for Women with two alcohol free days
- 17 standard drinks for Men with two alcohol free days

For men and women avoiding any alcohol on at least 2-3 days/week is important

Date: ____/____/____ Signature: _____ Discipline: _____

BODY WEIGHT

If any of the following are present refer to GP / MDT / Dietetics / SLT as appropriate

(Brief Intervention not indicated at this time)

- Unplanned weight change in past 3-6 months
- Taking oral nutritional supplement product
- Swallowing problems
- Unable to eat or drink
- Self induced vomiting/ bingeing/ taking non prescription diet pills/laxatives

Focus of Brief Intervention is healthy eating and limiting weight gain. BMI measurement (where feasible) is included to promote the routine measurement of BMI in practice.

1. BMI status

Height in metres _____

Weight in Kilos _____

BMI _____

Waist Circumference: _____

2. BMI Categories

Underweight BMI < 18.5

Healthy weight BMI 18.5- 24.9

Overweight BMI 25 - 29.9

Obese BMI >30

BMI not done/Not appropriate at this time

Service user declined/not interested

NUTRITION INTERVENTION

BMI < 18.5 UNDERWEIGHT

Referred to GP/MDT /dietetic services for nutritional screening

BMI 18.5 – 24.9 HEALTHY WEIGHT

Brief intervention (Emphasising benefits of and strategies to maintain healthy weight)

Signposted to www.hse.ie/healthyeatingactiveliving.ie; Healthy Food for Life Booklet

Service user declined/not interested

Service user capacity or decision making diminished

Family member/carer involved

BMI 25 - 30 OVERWEIGHT

Brief intervention (Emphasising the benefits of healthy eating, increasing fruit & vegetable intake, strategies to prevent weight gain)

Signposted to relevant resources/local weight management services (HSE or Private) www.hse.ie/selfmanagementsupport

Referred to dietetic services if 2 or more co morbidities exist

Service user declined/not interested

Service user capacity or decision making diminished

Family member/carer involved

BMI > 30 OBESE

Brief intervention (Emphasising the benefits of healthy eating, increasing fruit & vegetable intake, strategies to prevent weight gain)

Signposted to relevant resources/local weight management services (HSE or Private) www.hse.ie/selfmanagementsupport Referred to dietetic services

Service user declined/not interested

Service user capacity or decision making diminished

Family member/carer involved

Date: ____/____/____ **Signature:** _____ **Discipline:** _____

PHYSICAL ACTIVITY

1. In a typical week, how many days has the service user been physically active (PA) for total of 30 minutes or more?

(may not be suitable for those with eating disorders)

0 days (Inadequate)

1 - 4 days *

5 - 7 days (Adequate)

Unable to be physically active

No information available

*** IF SERVICE USER STATES 1-4 DAYS, ask if they engage in 150 minutes moderate activity or 75 minutes vigorous activity in a typical week?**

Yes (Adequate)

No (Inadequate)

No information available

PHYSICAL ACTIVITY INTERVENTION

SERVICE USERS REPORTING INADEQUATE ACTIVITY

(tick all actions taken)

Brief intervention on benefits of physical activity

Signposted to national websites www.getirelandactive.ie and www.lets-get-active-guidelines.pdf for support

Service user declined/not interested

Service user capacity or decision making diminished

Family member/carer involved

Physical Activity Guidelines for adults is at least 30 minutes of moderate intensity activity 5 days per week

Physical activity may include: walking/cycling for recreation or to get to and from places; gardening; and exercise or sport which lasts for at least 10 minutes

Date: ____/____/____ **Signature:** _____ **Discipline:** _____