Admission Documentation

Resident_______________________________ Date____________________

	Yes/No/NA
Order to admit/discharge summary signed by physician	
Physician notified of admission, admission orders verified	
Diagnosis given for each prescribed medication	
Orders transcribed to medication and treatment administration sheets	
Nurses' notes give time of admission, initial nursing assessment	
Inventory of resident possessions filled out, signed by resident or family	
Acute care plan implemented	
Allergies noted on chart and medication administration sheet	
Resident name band in place	
Diet order sent to dietary department	
Resident added to all census information	
All departments notified of admission	
Face sheet with vital information in chart	
Advance Directives in place	
TB test recorded with results	
Admission vital signs, height, and weight documented	
Labs ordered	
Fall risk assessment completed	
Skin breakdown assessment completed	
Pain assessment completed	

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