Nursing Admissions Exam

Name:	Date of Birth:	Height:
Present Address:		Weight:
City: State: Zip: Telephone:		
Current Diagnosis		
Physical Limitations		
Mental Health Limitations		
Allergies		
Treatment/Therapies (Describe medical services, nursing care, or other treatment needed.)		
Supportive Services Needed		
Diet Instructions: ☐ Regular ☐ No added table salt (NAS) ☐ No concentrated sweeteners ☐ Other (please specify):		

STATUS OF THE FOLLOWING (Please check all that apply):

AMBULATING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ Needs total help
- ☐ Bedridden

BATHING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ Needs total help

DRESSING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ Needs total help

EATING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ Needs to be fed
- ☐ Tube feeding

GROOMING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ Needs total help

SKIN INTEGRITY
- ☐ No pressure sores
- ☐ Stage one
- ☐ Stage two
- ☐ Stage three
- ☐ Stage four

Location

TOILETING
- ☐ Independent
- ☐ Needs supervision
- ☐ Hygiene assistance
- ☐ Adult briefs
- ☐ Catheter Care Assist
- ☐ Ostomy

TRANSFERRING
- ☐ Independent
- ☐ Needs supervision
- ☐ Needs assistance
- ☐ Needs total help

RESTRAINTS
- ☐ Requires no restraints
- ☐ Requires chemical restraints (A)
- ☐ Requires physical restraints (B)

Type (A) **Type (B)**

Signed: **Date:**