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| Patient Label |
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## Pre-Admission Part I - Continued

| HEALTH HABITS AND PERSONAL SAFETY                                                                                  |                                                                                                                                                                       |
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| <b>Assistive Devices/</b>                                                                                          | * Oxygen _____ liters * CPAP * BIPAP                                                                                                                                  |
| <b>Home Medical</b>                                                                                                | * Walker * Cane * Crutches * Prosthetics * Mobility Limitations (include neck/back):                                                                                  |
| <b>Equipment</b>                                                                                                   | Glasses * Contact Lens * Hearing aids: * Left * Right                                                                                                                 |
|                                                                                                                    | * Upper Denture * Lower Denture * Partial Denture                                                                                                                     |
|                                                                                                                    | * Home Health, Agency:                                                                                                                                                |
| <b>Social Needs</b>                                                                                                | <input type="checkbox"/> Lives with spouse, significant other, or adult who can provide care to patient after procedure.                                              |
| <b>Personal Safety</b>                                                                                             | <input type="checkbox"/> Lives alone, List person to provide care after procedure: _____<br>Contact number: _____                                                     |
|                                                                                                                    | <input type="checkbox"/> Has no one available to provide care after procedure.                                                                                        |
|                                                                                                                    | <input type="checkbox"/> Home Health/Agency Referral Requested <input type="checkbox"/> MD Notified: _____<br>Date: _____ Time: _____                                 |
| <b>Alcohol</b>                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you need assistance to stop drinking alcohol?                                                             |
|                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Referral to Agency requested (AA, Support Group, Counselor)                                                  |
| <b>Tobacco</b>                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you need assistance to quit using tobacco?                                                                |
|                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Time: _____ Physician Name: _____ Patient Primary Care Physician notified of need for assistance |
| <b>Advance Directives</b>                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have Advance Directives or Living Will                                                                |
|                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you need more information on these documents?                                                             |
| <b>ETASC Personnel – Information Given to upon arrival</b>                                                         |                                                                                                                                                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Patient informed of ETASC Advance Directive Policy</b> |                                                                                                                                                                       |
| <b>Substance Abuse</b>                                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Time: _____ Physician Name: _____ Patient Primary Care Physician notified of need for assistance |
|                                                                                                                    | <input type="checkbox"/> Has no one available to provide care after procedure.                                                                                        |
| <b>Mental Health</b>                                                                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any Psychiatric illness requiring treatment?                                                     |
|                                                                                                                    | Describe:                                                                                                                                                             |
|                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any Mental Health concerns or issues?                                                            |
|                                                                                                                    | Describe:                                                                                                                                                             |
|                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Primary Care Physician notified of patient needs, if applicable.                                             |
|                                                                                                                    | Physician _____ Date _____ Time _____                                                                                                                                 |

**Nurses Notes:**

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**Preadmission Nurse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_