This form should only be used for information collected on the 29/01/2025

First Name	CLIENT	Surname	TEST	Date of Birth	29/01/1902
NHS Number		Service		Ward	

Highlight Discharge Summary fields

This form has no significant events. Click here to view or add significant events

ADMISSION ASSESSMENT / PHYSICAL EXAMINATION

Part 1 - Admission Assessment

To be completed on admission and combined with Full Discharge Report on discharge

Care Co-ordinator			
First Name		Last Name	
Address			
Line 1		Line 4	
Line 2		Line 5	
Line 3		Postcode	

Inpatient Consultant			
First Name		Last Name	
Report prepared by			
First Name		Last Name	

Date of Admission	DD/MM/YYYY -	Legal Status	
ICD10 Code			

Reason for admission *(include recent life situation)*	

Signature		Date Completed	29 Jan 2025
First Name		Last Name	
Designation			

Form 16.2-00-CP
(Part 2 of 8)

First Name	CLIENT	Surname	TEST	Date of Birth	29/01/1902
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Source for admission	
History of presenting complaint	

Family History

Family History 1 *(including parents / siblings, family psychiatric history)*

Personal history *(including birth and early development, education, occupational history, psychosexual / marital history, personal habits, premorbid personality)*	
Previous psychiatric history	
Medical history	
Medicines on admission	

Allergies and adverse reations

First Name	Last Name	Designation	Date Completed
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Form 16.2-00-CP

(Part 3 of 8)

First Name	CLIENT	Surname	TEST	Date of Birth	29/01/1902
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Causative Agent 1	
Comments	

Smoking	
Does the patient smoke?	

Substance Misuse	
Does the patient use illegal substances?	

Alcohol	
Drinks Alcohol	

Drug, Smoking and Alcohol history	
Forensic history	
Premorbid Personality *(Cluster A, B or C with personality traits)*	

Mental State Examination	
Appearance and behaviour	
Speech	

First Name	Last Name	Designation	Date Completed
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Form 16.2-00-CP
(Part 4 of 8)

First Name	CLIENT	Surname	TEST	Date of Birth	29/01/1902
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Mood	
Thoughts	
Perceptions	
Cognitive Functions	
Insight	
Risk Assessment	
Provisional Diagnosis	

Does the patient agree to have a physical Health check	**Yes**	○	**No**	○

Physical Examination		
General Inspection *(Tick if present and specify)*		
Bruises	☐	

First Name	Last Name	Designation	Date Completed
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Form 16.2-00-CP
(Part 5 of 8)

First Name	CLIENT	Surname	TEST	Date of Birth	29/01/1902
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Injuries	☐	
Oedema	☐	
Anaemia	☐	
Cyanosis	☐	
Jaundice	☐	

Height	200	Weight	89	LMP	
BMI	22.2	Temperature			

Cardiovascular Examination										
Pulse BPM	100	Rhythm	Regular	○	Irregular	○	BP		/	mmHg
Heart Sounds		Murmur	Yes	○	No	○	JVP			

Details of respiratory assessment						
Auscultation		Respiratory rate		/min	Cyanosis	
		Sats			Clubbing	
		Peak			Lymphadenopathy	

Has a VTE Assessment been completed	Yes	○	No	○
Has a Visual assessment & baseline GCS been completed if patient is at Risk of fall	Yes	○	No	○

Please complete cardio metabolic form

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Form 16.2-00-CP
(Part 6 of 8)

First Name	CLIENT	Surname	TEST	Date of Birth	29/01/1902
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Abdominal Examination:							
Tenderness		Bowel Sounds					
Distension		Bowels Open	Yes	○	No	○	
Masses		Passing Urine	Yes	○	No	○	
Hernia							

Neurological Examination							
PUPILS	Left	Right	MOTOR	RT UL	LT UL	RT LL	LT LL
Size			Wasting				
Reactive to light			Fasciculation				
Accommodation			Tone				
Eye movements			Power				
Other Cranial Nerve Abnormalities			Coordination				

	Deep Reflexes			Sensation			
	Left	Right		RT UL	LT UL	RT LL	LT LL
Biceps			Cotton wool				
Triceps			Pin prick				
Supinator			Vibration				
Knee			Joint sense				
Ankle			Gait				
Planter Response			Extrapyramidal signs				

First Name	Last Name	Designation	Date Completed
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Form 16.2-00-CP

(Part 7 of 8)

First Name	CLIENT	Surname	TEST	Date of Birth	29/01/1902
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Item	Yes/No				Comments
History of healthcare associated infection i.e. MRSA	Yes	○	No	○	
Clostridium Difficile	Yes	○	No	○	
Diarrhoea of unknown cause on admission	Yes	○	No	○	
Has the patient tested positive for HIV	Yes	○	No	○	
Has the patient tested positive for HEP B	Yes	○	No	○	
Has the patient tested positive for HEP C	Yes	○	No	○	
Infestations head and / or Body Lice and / or Scabies	Yes	○	No	○	
History of alcohol misuse *(Above 4 units / day. Complete Alcohol Withdrawal Scale - S. Consider alcohol detox if the score is above 2)*	Yes	○	No	○	

Additional Details	

Treatment Plan	

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Form 16.2-00-CP

(Part 8 of 8)

First Name	CLIENT	Surname	TEST	Date of Birth	29/01/1902
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Does the patient have...

Confusion Assessment Method *(CAM) Diagnostic Algorithm*

Does the patient have...

1) Acute onset and fluctuating course	**Yes**	○	**No**	○
2) Inattention, distractibility	**Yes**	○	**No**	○
3) Disorganized thinking, illogical or unclear ideas	**Yes**	○	**No**	○
4) Alteration in consciousness	**Yes**	○	**No**	○

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