Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

ACUTE NURSING PSYCHIATRIC ASSESSMENT

Name:		**PARIS ID:**
DOB:	**Age:**	**PHN:**
Gender:		**Phone:**
Home Address:		

Assessment Start Date: **Assessment End Date:**

Reason For Assessment: **Carried Out By:**

Communication and Status

Time of admission to unit

Information obtained from ☐ Patient ☐ Family ☐ Friend

☐ Family NOT to be informed of admission

Date last seen by physician/psychiatrist

☐ Voluntary ☐ Involuntary Date Certified

Completed Forms ☐ 4(1st) ☐ 4(2nd) ☐ 5 ☐ 6 ☐ 13 ☐ 15 ☐ 20 ☐ Hospital Consent

Level of Observation ☐ Close Observations ☐ One to One ☐ Seclusion ☐ Personal Clothing ☐ PJs

Legal Status [MRR]

Legal Status Type	Start Date	End Date	Recorded By	Date Recorded	Team Name

Vital Signs

Recorded Date	BP Sitting	BP Standing	BP Lying	Per Min.	Heart Rate	Resp	Cel. Fah.	Comments	Recorded By

Glucometer

Glucometer ☐ YES ☐ NO ☐ NA

General Description

Eye colour, hair colour, additional identifying features.

Weight And Growth Chart

Date Measured	Age	---- Weight ---- kg %ile	--- Height --- cm %ile	----- BMI ----- %ile	------ Head ------ Circumference cm %ile	---% Birth --- Wgt Lost	-- Wgt for -- Length %ile	--- Waist --- Hip cm ratio

Comments:

Languages & Communication

Language Type	Method	Fluency	Status	Level of Understanding	Main Language	Interpreter
					☐	☐

ACUTE NURSING PSYCHIATRIC ASSESSMENT

Name:	PARIS ID:

Diagnosis

Date	Diagnosis Type	Diagnosis	State	Aware?	Comments

Reason for Referral

History of Presenting Problem

Arrival To Unit

From where, with whom, walking or wheelchair. Describe patient.

Mental Status

Appearance, attitude, behaviour, mood and affect, speech, thought process, thought content, perceptions (e.g. hallucinations), cognition (e.g. alertness, orientation, attention, concentration, memory, visuospatial, language and executive functions), insight and judgment.

Risks

Suicidal thoughts	☐ YES	☐ NO	Describe
Suicidal plan	☐ YES	☐ NO	Describe
Previous suicide attempts	☐ YES	☐ NO	Describe
Homicidal thoughts	☐ YES	☐ NO	Describe
History of violence	☐ YES	☐ NO	Describe
Self harm behaviour	☐ YES	☐ NO	Describe
Code White Identified	☐ YES	☐ NO	☐ N/A
Alert Initiated	☐ YES	☐ NO	☐ N/A
BPRS Completed	☐ YES	☐ NO	

Name:	PARIS ID:

Allergies - Current *Content may have been entered/updated after assessment completed.*

Date Entered	Allergen	Category	Source	Reaction	Reaction Details

Systems Review

Include past hospitalization and surgeries

Respiratory - SOB, pulmonary emboli, wheezing, sputum, recent URI, asthma, cough, TB

☐ Reviewed and no concerns identified

Cardiac - palpitations, hypertension, murmurs, fainting, chest pain, dizziness, dyspnea, pacemaker, usual BP

☐ Reviewed and no concerns identified

Neurological - seizures, altered sensation, CVA, paralysis, numbness/tingling, migraines, dizzy spells

☐ Reviewed and no concerns identified

Musculoskeletal - stiffness, muscle/joint pain, weakness, decreased ROM, back pain, history of falls, arthritis, unsteady gait

☐ Reviewed and no concerns identified

Peripheral Vascular - varicose veins, phlebitis, edema (ankles, etc), CWMS, bleeding problems, DVT, anemia, vascular access: tunneled cath IAD

☐ Reviewed and no concerns identified

Skin - broken areas, bruises, lesions, rashes, reddened areas, existing decubitus

☐ Reviewed and no concerns identified

GI - jaundice, constipation, diabetes, diarrhea/incontinence, nausea, vomiting, ostomy, recent weight change, bowel pattern/characteristics

☐ Reviewed and no concerns identified

Last Bowel Movement ☐ Bowel Protocol Initiated

GU/Gyne - nocturia, frequency, burning, retention, kidney stones, urinary incontinence, recent UTI, ostomy, discharge (penile, vaginal)

☐ Reviewed and no concerns identified

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Name:	PARIS ID:

Systems Review (continued)

Immune - hepatitis, transfusions, infections (acute/chronic), HIV/AIDS

☐ Reviewed and no concerns identified

Recent travel

Recent contact with communicable disease

Medication Reconciliation Completed? YES ☐ NO ☐

If No, Reason

Sleep/Rest Patterns

Hours per night Nap: ☐ YES ☐ NO

Other

Problems:

- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Sleep Apnea
- ☐ Sleep Walking
- ☐ Nightmares
- ☐ Other:

Living Arrangements

Household (Alone, Partner/Spouse, Family, Group Setting), House Type (House, Nursing Home, Group Home, Apt, # of stairs) and recovery plans on discharge

Mobility (pre-hospitalization) - independent, cane, walker, wheelchair, activity level

Community/Support and Resources

Identification Of Valuables And/Or Clothing

Include amounts of money and if sent to safekeeping, tobacco, own meds, weapons, drugs of abuse and how disposed of.

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Substance Use

CAGE Score / 4

CIWA tool required? YES ☐ NO ☐ Score:

☐ Illicit drug use identified

☐ DRUG REGIME INITIATED

Nicotine Replacement Initiated? YES ☐ NO ☐

☐ Reviewed and no concerns identified

Substance Use Comments

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Substance Use [MRR]

Substance Use: **Not Assessed** **No Identified Issues**

Prim Prob	Substance	Primary Route	Date Last Used	# Days of use in last 30 Days	Typical Day Amt Used	Age at First Use	Current Pattern	Stage of Change
	Alcohol							
	Non-beverage Alcohol							
	Tobacco							
	Cannabis							
	Crack Cocaine							
	Cocaine							
	Heroin							
	Opioids:							
	Opioids:							
	Benzos:							
	Benzos:							
	Crystal Meth							
	Amphetamines							
	Club Drugs:							
	Hallucinogens:							
	Inhalants:							
	Over-the-Counter Drugs (exc. codeine):							
	Other Prescription Drugs (exc. opioids):							
	Other:							
	Other:							

Has client shared needles with other users within the last 30 days?	Yes	No	Unknown	Not Applicable

Summary

Name:	PARIS ID:

Other People Involved

Copies To Be Sent To:

Other Authorizers

Other Authorizer: **Date:**

Other Authorizer: **Date:**

Authorization Details

Carried Out By: **Date:**

Closing Authorizer: **Date:**

Notes:

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

----------End of Report ----------