**CLOSE OBSERVATION NURSING ASSESSMENT**

**DATE OF ADMISSION TO RESTRICTIVE HOUSING**

**FACILITY**

**REASON FOR PLACEMENT**

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**Instructions:** To be completed for all patients placed in Close Observation in accordance with Nursing Procedures. (For other restrictive housing use 13-432)

**PRIMARY CARE PROVIDER**

**PRIMARY THERAPIST**

**RESTRAINTS (Use DOC 13-560 if indicated)**

- No [ ]
- Yes [ ]
- Type:

**ALLERGIES (meds or food)**

- None [ ]

**MEDICATIONS**

- None [ ]
- Attached [ ]

**CHRONIC MEDICAL CONDITIONS**

- None [ ]

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**MEDICATIONS TO BE KEPT ON PERSON OR AVAILABLE IMMEDIATELY UPON REQUEST**

- Inhaler [ ]
- Nitro [ ]
- Other: 

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**SCREENING (explain any “Yes” answers)**

- Glasses? [ ] No [ ] Yes
- Artificial limbs? [ ] No [ ] Yes
- Contacts? [ ] No [ ] Yes
- Hearing aids? [ ] No [ ] Yes
- Dentures? [ ] No [ ] Yes
- Other? [ ] No [ ] Yes
- (FEMALE) Pregnant or suspected pregnancy? [ ] No [ ] Yes

“Yes” explanations: 

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**ADMISSION ASSESSMENT (explain any “Yes” answers in the Comments below)**

**BP:** _____ / _____ **Pulse:** _______ **RR:** _______ **O₂ Sat:** _______ **Wt:** _______

**Mental Status:**

- Oriented to person, place, and time? .......................................................... [ ] No [ ] Yes
- Any history of treatment for a mental health disorder? ........................................... [ ] No [ ] Yes
- Any history of suicide ideation/attempts or current thoughts of suicide? .................... [ ] No [ ] Yes
- Is this admission related to a suicide attempt? .................................................... [ ] No [ ] Yes

**Physical Assessment:**

- Any difficulty breathing? ........................................................................... [ ] No [ ] Yes
- Any nausea or vomiting? ........................................................................... [ ] No [ ] Yes

**Signs of Trauma:**

- Any recent head injury or complaining of nausea and vomiting? ...................... [ ] No [ ] Yes
- Any visible body marks or lacerations indicating new or recent trauma? ................ [ ] No [ ] Yes
- Any signs of bleeding? .............................................................................. [ ] No [ ] Yes
- Any obvious physical or anatomical deformities? ............................................ [ ] No [ ] Yes

**Comments:** 

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**NURSING PLAN OF CARE**

**Assessment:** [ ] Every shift [ ] Daily **Vital signs:** _____ times a day [ ] Daily [ ] As Needed

**Plan:** 

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Assessment continued on back
### CLOSE OBSERVATION NURSING ASSESSMENT

<table>
<thead>
<tr>
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**Based upon above information and findings,**

- [ ] Urgent/emergent mental health evaluation by a mental health provider is indicated.
- [ ] Urgent/emergent medical evaluation by a practitioner and/or transfer to medical unit is indicated.
- [ ] Patient appears to be medically suitable at this time for restrictive housing confinement.

Practitioner/MH Provider notified: _______________________________ Date: _______________ Time: _______________

Recommendations: _______________________________ Date: _______________ Time: _______________

- [ ] Orders received and documented on DOC 13-435 Primary Encounter Report

**Completed by** (typed or stamped name) | **Signature** | **Date / Time**

**Reviewed by** (when required) (stamped name) | **Signature** | **Date / Time**

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Use 13-556 Close Observation Progress Record for continued daily assessments.