PATIENT I.D. DATA:
(name, DOC #, birthdate)

CLOSE OBSERVATION NURSING ASSESSMENT

DATE OF ADMISSION TO RESTRICTIVE HOUSING	FACILITY	REASON FOR PLACEMENT

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

MEDICATIONS TO BE KEPT ON PERSON OR AVAILABLE IMMEDIATELY UPON REQUEST

☐ Inhaler ☐ Nitro ☐ Other: ____________________

SCREENING (explain any "Yes" answers)

Glasses?	☐ No	☐ Yes	Artificial limbs?	☐ No	☐ Yes	Significant medical/dental problems/history?
Contacts?	☐ No	☐ Yes	Hearing aids?	☐ No	☐ Yes	☐ No ☐ Yes
Dentures?	☐ No	☐ Yes	Other?	☐ No	☐ Yes	(FEMALE) Pregnant or suspected pregnancy?
Partials?	☐ No	☐ Yes				☐ No ☐ Yes

"Yes" explanations: ____________________

____

ADMISSION ASSESSMENT (explain any "Yes" answers in the Comments below)

BP: ______ / ______ Pulse: ________ RR: ________ O_2 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: ____________________

____

____

NURSING PLAN OF CARE

Assessment: ☐ Every shift ☐ Daily Vital signs: _____ times a day ☐ Daily ☐ As Needed

Plan: ____________________

____

____

Assessment continued on back

PATIENT I.D. DATA:
(name, DOC #, birthdate)

CLOSE OBSERVATION NURSING ASSESSMENT

DATE OF ADMISSION TO RESTRICTIVE HOUSING	FACILITY	REASON FOR PLACEMENT

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: ____

☐ 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

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

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.