HOSPITAL PRE-ADMISSION INFORMATION FOR PERSONS WITH SPINAL CHORD INJURY

TO BE COMPLETED BY PATIENT			
Hospital		Date	
Name		Language	
Address			
Emergency person		Relationship	
Emergency number			
Spinal cord injury diagnosis			
Treatment/operations received			
Chronic conditions or other medical issues			
Allergies			
I have suffered from Autonomic Dysreflexia		I am at risk of suffering from Autonomic Dysreflexia	

Relevant Clinical Information

TO BE COMPLETED BY PATIENT	
Information	**Yes / No / Comment**
Level of spinal injury	
Date of injury	
Do you have loss of sensation? Where?	
Do you have spasms which we should be aware of?	
Do you have specific areas of pain?	
How do you manage your pain or spasms?	
Do you need a special mattress or cushions?	
Action Plan (To be completed by the relevant hospital staff in consultation with the patient):	

Communication	
Activity	**Yes / No / Comment**
Can you use the hospital nurse-call system?	
What other calling device can you use?	
Action Plan (To be completed by the relevant hospital staff in consultation with the patient):	

Eating and Drinking	
Activity	**Yes / No / Comment**
Can you feed yourself?	
Do you use specialised feeding utensils?	
Can you pour your own drink?	
What do you drink from (straw, feeding cup, glass)?	
Is there a special diet that you want to maintain?	
Action Plan (To be completed by the relevant hospital staff in consultation with the patient):	

Toilet Routine	
Activity	**Yes / No / Comment**
What is your regular bladder routine?	
What is your regular bowel routine?	
Do you require the use of a commode?	
Action Plan (To be completed by the relevant hospital staff in consultation with the patient):	

Personal Hygiene and Dressing	
Activity	**Yes / No / Comment**
What is your personal bathing routine?	
What assistance do you require to bath/shower?	
What assistance do you require to shave?	
Are you able to judge the water temperature?	
What assistance do you require to dress?	
Action Plan (To be completed by the relevant hospital staff in consultation with the patient):	

Controlling Body Temperature & Skin Integrity	
Activity	**Yes / No / Comment**
Do you have difficulty maintaining normal body Temperature?	
Do you have any area that is vulnerable to skin breakdown?	
What is your pressure relieving routine?	
What assistance do you require?	
Do you currently have any pressure sores?	
Are they dressed?	
Action Plan (To be completed by the relevant hospital staff in consultation with the patient):	

Mobilisation	
Activity	**Yes / No / Comment**
Are you able to pull yourself up in bed?	
Are you able to roll in bed?	
Can you transfer independently?	
How many people do you require to transfer bed-chair-bed?	
Do you require special equipment to transfer?	
What is your preferred transfer method?	
Action Plan (To be completed by the relevant hospital staff in consultation with the patient):	

Sleeping	
Activity	**Yes / No / Comment**
Do you have a preferred side to sleep on?	
Do you have a specific way to be turned at night?	
What is your night-time turning routine?	
Do you require extra pillows at night?	
Do you require a CPAP / BiPAP machine?	
Action Plan (To be completed by the relevant hospital staff in consultation with the patient):	