# Health Share Nursing Assessment

| Staff Name: | Date: |
|---|---|

| Member Information | |
|---|---|
| Member Name: | Date of Birth: |
| Time of Assessment: | |
| Allergies: | |
| Reason for Admission (Per Member): | |
| Nursing Note: | |
| Drug of Choice: | |
| DSM-5 Codes: | |

| Drug Use History | | | | |
|---|---|---|---|---|
| Substance | First Use | Route | Amount | Last Use |
| | | | | |
| | | | | |
| | | | | |

| |
|---|
| Past Detox/Withdrawal Symptoms and Treatment: |
| Current Withdrawal Symptoms: |
| Current CIWA or COWS Score: |
| History of Withdrawal Seizures: |
| Medical History: |
| Psychiatric History: |
| UDS Results: |
| BAC: |
| Medications Taken on a Regular Basis: |
| Most Recent Pharmacy: |

| Vital Signs |
| --- |
| Temperature: |
| Blood Pressure: |
| Heat Rate: |
| Respirations: |
| O2 SAT: |
| Pain: |
| Reported Weight: |
| Reported Height: |
| Skin Assessment: |
| ADLs: |

| Mental Status Exam |
| --- |
| Appearance: |
| Behavior: |
| Speech: |
| Affect: |
| Attitude to Examiner: |
| Mood: |
| Thought Process: |
| Thought Content: |
| Cognition: |
| Insight: |
| Judgement: |
| Past Medical Hospitalization History: |
| Primary Care Doctor Name: |
| Most Recent Visit with Primary Care Doctor: |

**NEEDS:**

1) Client Identified:

2) Staff Identified, medication management for detox from:

**REFERRALS**: (e.g. Outpatient treatment, Medication management, Smoking cessation)

1.

**RECOMMENDATIONS:**

1.

**DIETARY:**

**NURSING DISCHARGE PLANNING:**

Signature of Nurse Date

Printed Name