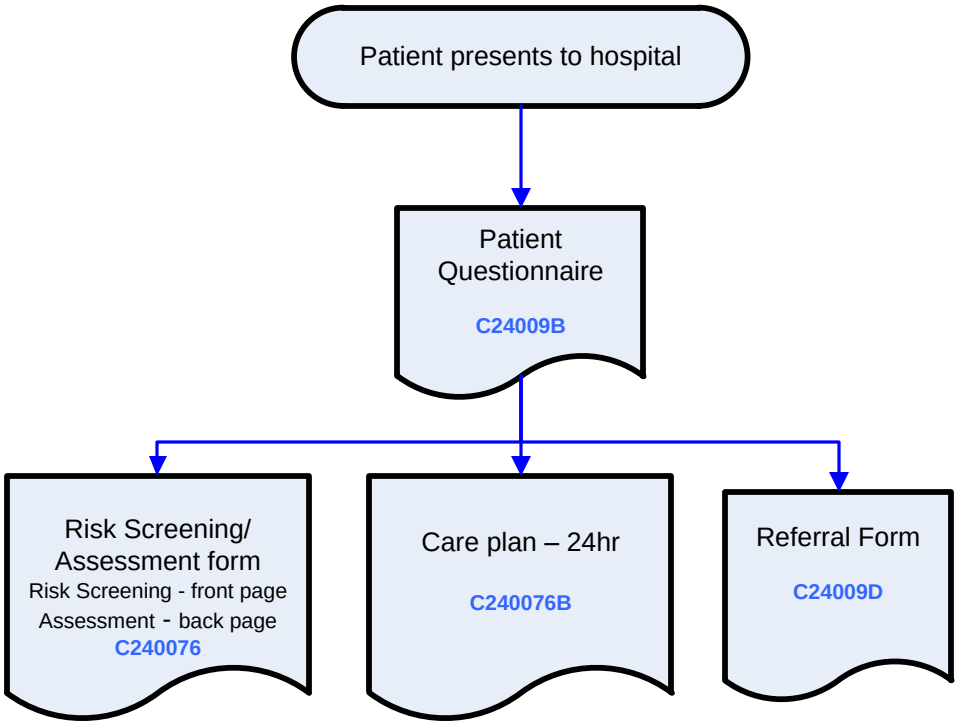


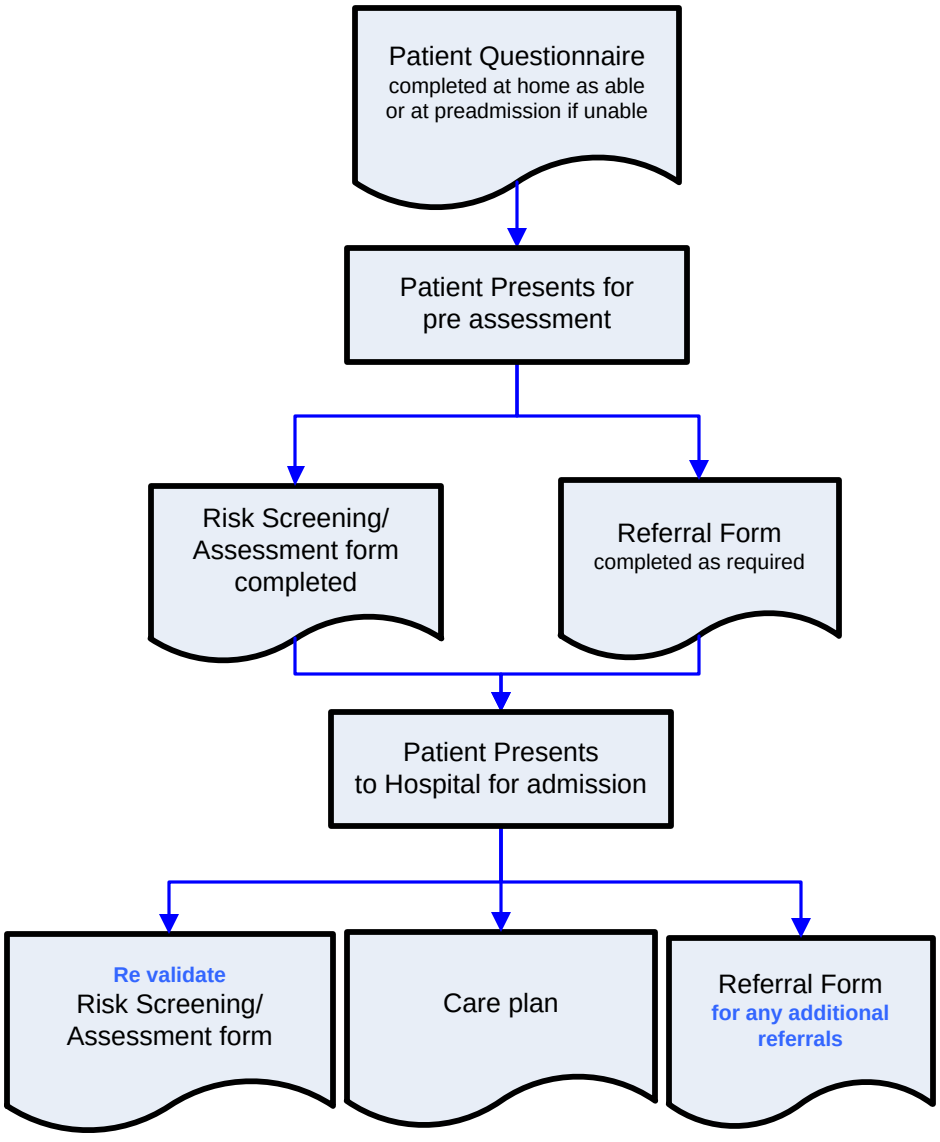
Acute Admission Instructions

Offer patient questionnaire on presentation as appropriate (this assists with the risk screening documentation)

Start Risk Screening section of the Risk Screening/Assessment document at point of presentation

Complete the rest of the Risk Screening section (within 6 hrs) and Assessment section (asap) on admission with the Care plan and Referral form (this ensures you can document strategies and make referrals as you complete the risk screening/assessment form)

New care plan document rewritten at the beginning of every 24 hr period



Pre assessment followed by Admission Instructions

Patient Questionnaire either completed prior to visit or at pre assessment visit

Risk Screening/Assessment form completed and referrals sent

On admission the admitting nurse must review the pre assessment Risk screening/Assessment form to ensure all information is still current.

NURSE MUST SIGN IN THE SIGN OFF SECTIONS AND ASTERIX THEIR NAME
Changes on the form also need to be identified by an asterix

Complete rest of the Risk Screening/ Assessment form on admission with the Care plan and Referral form (this ensures you can document strategies and make referrals as you complete the risk screening/assessment form)

New care plan completed at the beginning of every 24hr period