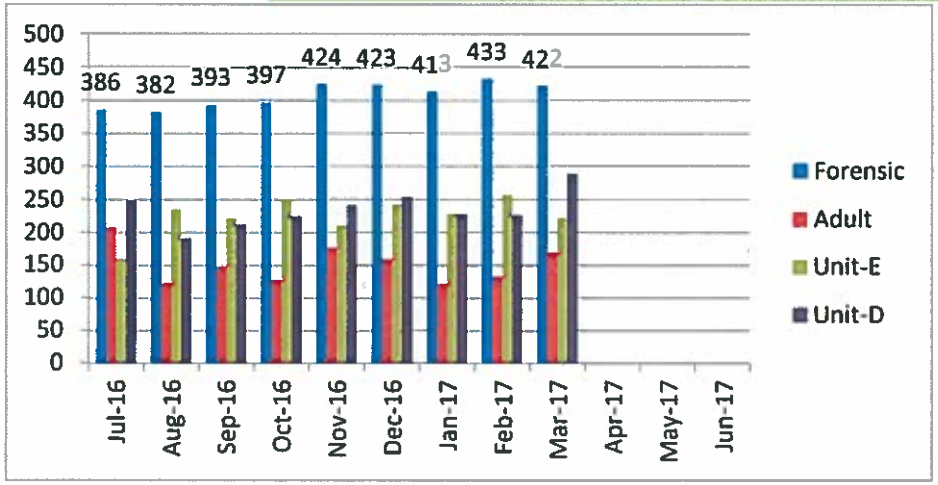
Fiscal Year -17

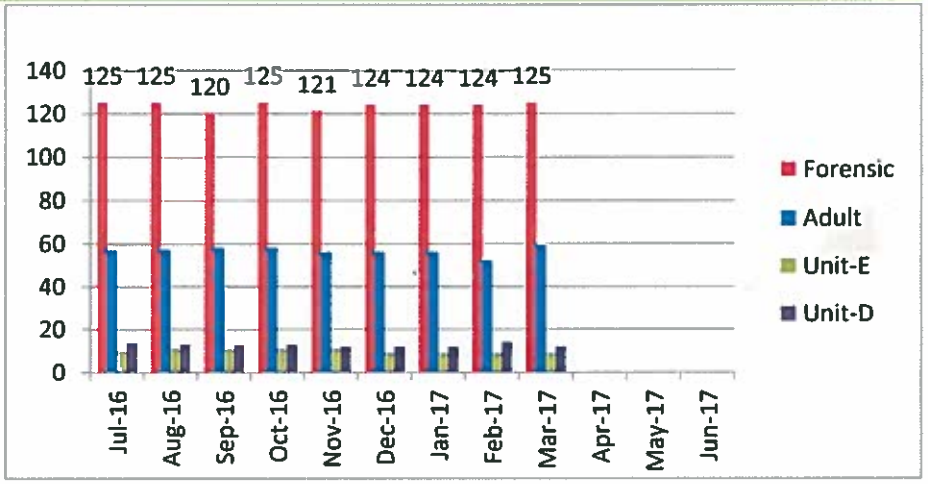
Average Length of Stay -(Days)	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	FY Avg. for FY17
Forensic	386	382	393	397	424	423	413	433	422				408
Adult	209	124	149	129	178	160	123	134	170				153
Unit-E	161	236	222	252	211	243	229	257	222				226
Unit-D	249	192	213	226	242	255	228	227	289				236
Hospital	354	351	371	354	380	395	271	306	395				353

Average daily Census / Month	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Census Avg. for FY17
Forensic	125	125	120	125	121	124	124	124	125				124
Adult	57	57	58	58	56	56	56	52	59				57
Unit-E	10	11	11	11	11	9	9	9	9				10
Unit-D	14	13	13	13	12	12	12	14	12				13
Hospital	207	207	202	208	200	202	200	203	205				204

AVERAGE LENGTH OF STAY BY PROGRAM FY-17



AVERAGES BEDS USE PER PROGRAM FY-17



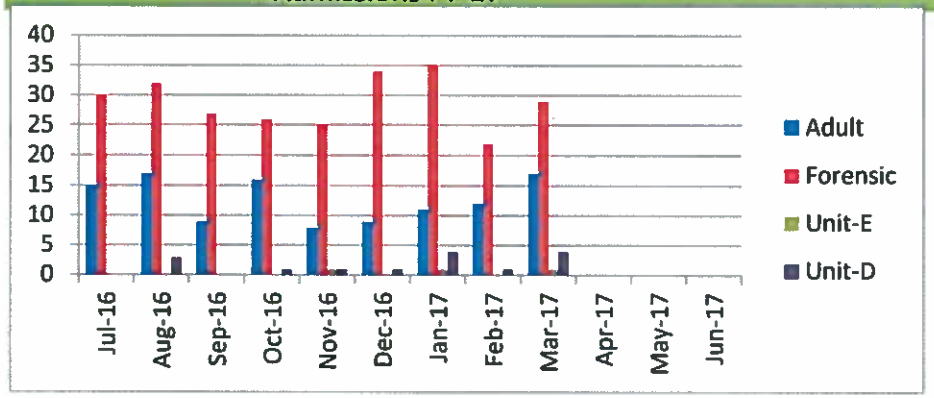
Admissions

Fiscal Year -17

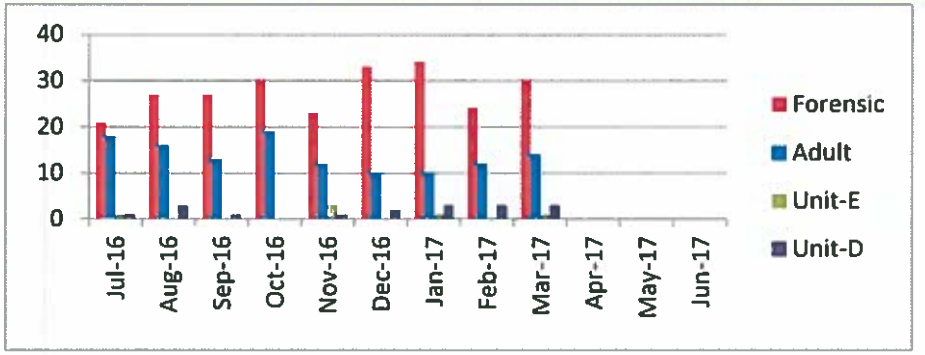
Admissions	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	total Admits for FY-17
Forensic	30	32	27	26	25	34	35	22	29				260
Adult	15	17	9	16	8	9	11	12	17				114
Unit-E	0	0	0	0	1	0	1	0	1				3
Unit-D	0	3	0	1	1	1	4	1	4				15
Hospital	45	52	36	43	35	44	51	35	51	0	0	0	392

Discharges	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Total D/Cs for FY-17
Forensic	21	27	27	30	23	33	34	24	30				249
Adult	18	16	13	19	12	10	10	12	14				124
Unit-E	1	0	0	0	3	0	1	0	1				6
Unit-D	1	3	1	0	1	2	3	3	3				17
Hospital	41	46	41	49	39	45	48	39	48	0	0	0	396

Admissions FY-17



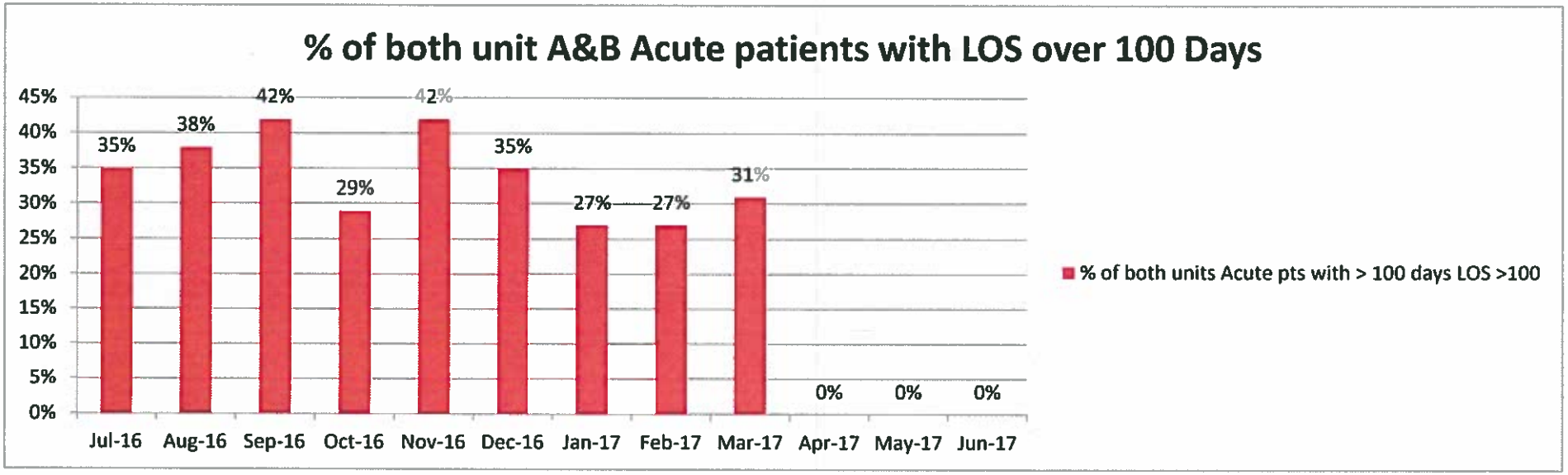
Discharges FY-17



Admissions

Fiscal Year -17

Acute patients on Units A & B that LOS is over 100 days	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	FY17 total days Over A&B
Unit-A	1395	1256	1436	1541	1698	1506	1542	1222	1233				12829
Unit -B	741	926	728	431	491	561	425	437	571				5311
Total days over	2136	2182	2164	1972	2189	2067	1967	1659	1804	0	0	0	18140
# A&B pts LOS <100 days	9	11	11	7	8	8	7	6	12				79
Total Acute pts on Units A&B	26	29	26	24	19	23	26	22	17				212
% of both units Acute pts with > 100 days LOS >100	35%	38%	42%	29%	42%	35%	27%	27%	31%				35%



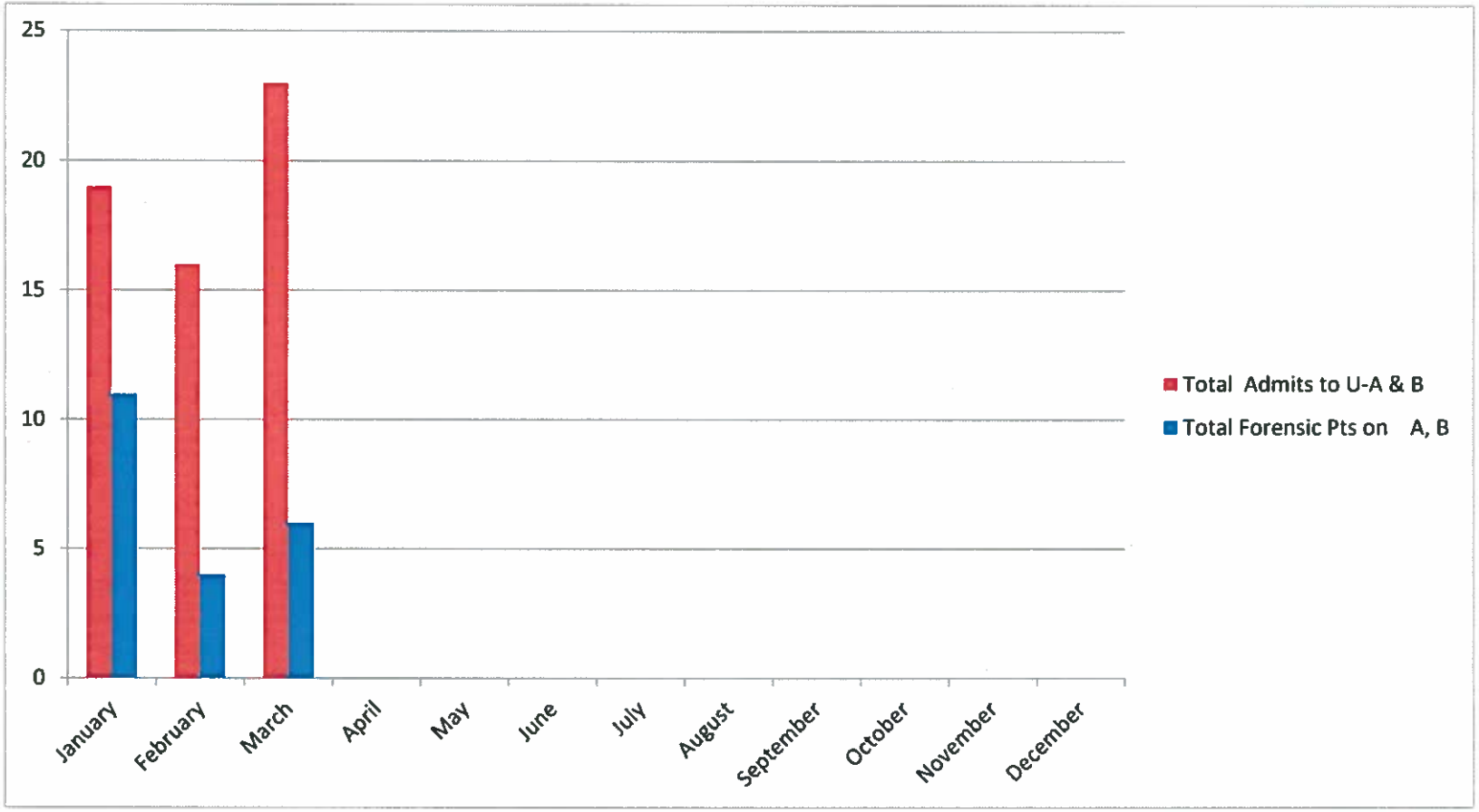
Admissions

2017 Forensic Admissions to Adult Acute Units A B

2017		A					B					911	310	314	305			
	Total Forensic Pts on A, B	Total Forensic	911	310	314	Forensic 45/180/7 days 305	Total Forensic	911	310	314	Forensic 45/180/7 days 305					Total Admits to A	Total Admits to B	Total Admits to U-A & B
January	11	6	2	4	0	0	5	3	0	2	0	5	4	2	0	10	9	19
February	4	2	2	0	0	0	2	1	1	0	0	3	1	0	0	8	8	16
March	6	3	1	2	0	0	3	2	1	0	0	3	3	0	0	14	9	23
April	0	0					0					0	0	0	0			0
May	0	0					0					0	0	0	0			0
June	0	0					0					0	0	0	0			0
July	0	0					0					0	0	0	0			0
August	0	0					0					0	0	0	0			0
September	0	0					0					0	0	0	0			0
October	0	0					0					0	0	0	0			0
November	0	0					0					0	0	0	0			0
December	0	0					0					0	0	0	0			0
	21	11																
							0											
Total Forensic pts A,B	21	11	5	6	0	0	10	6	2	2	0	11	8	2				
total Admits to units A-B	58	32					26									32	26	58
% of Forensic Pts on units A-B	36%	34%					39%											
		30 beds					30 beds											

@Admissions

2017 Forensic Admissions to Adult Acute Units A B



Admissions

Front

VALUABLES ENVELOPE

ARKANSAS STATE HOSPITAL
4313 W. Markham St.
Little Rock, AR 72205

No. 9969

To be signed when valuables are deposited.

Signature of Depositor _____

Received by _____

Date _____

Contents to be surrendered to owner only after signature on depositor's receipt has been witnessed and compared by custodian.

CONTENTS (To be listed at option of depositor)		

FORM 743-BRIGGS CORPORATION (800-247-2343)

PSO

Back

VALUABLES ENVELOPE

SEAL SECURELY IN PRESENCE OF

PERSON DEPOSITING VALUABLES

ARKANSAS STATE HOSPITAL
4313 W. Markham St.
Little Rock, AR 72205

No. 9969

This receipt MUST BE SIGNED IN THE PRESENCE OF THE CUSTODIAN when the valuables which have been deposited are called for. Valuables will be surrendered only to the person who has deposited them and whose signature appears on the face of the envelope.

Signature of Depositor _____

Delivered By _____

Date _____

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SUBMITTED PROPERTY TRACKING SHEET

DATE:_____

PATIENT NAME:_____ UNIT:_____

RECEIVING OFFICER:_____ Call#:_____

Person Submitting Property:_____

Quantity	Item	COMMENTS
	Socks	
	Underpants	
	Undershirts	
	Bra's	
	Sweat Pants	
	Sweat Shirts	
	Jeans, Slacks	
	Shorts	
	T-Shirts	
	Dress Shirt	
	Blouses	
	Dress	
	Suit/ Sport Coats	
	Jackets	
	Coat	
	Shoes	
	Pajama's / Gowns	
	Robes	
	Body Wash	
	Deodorant	
	Hair Grease	
	Lotion	
	Batteries	
	Books / Magazines	
	Miscellaneous	

HISTORY OF POSSESSION				
From	To	Date	Time	Reason
VISITOR: X	PSO/PSSO:			INTAKE
PSO/PSSO:	PROPERTY ROOM			PROPERTY ROOM
PSO/ PSSO	Unit Representative			UNIT

(Have Person Submitting Property to Front Desk ,Sign by the "X")

PSO

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
POLICE INCIDENT REPORT

INCIDENT REPORT #
2017-0000

STATUTE #	CLASSIFICATION: N/A	INCIDENT NATURE	DATE OF REPORT
§ N/A	☐ Misd ☐ Fel		

LOCATION OF INCIDENT	DAY OF WEEK	DATE OF INCIDENT	TIME OF INCIDENT (24Hr Format)

Complainant:	ADDRESS	CITY	STATE	ZIP	PHONE

INCIDENT REPORTED TO: ☐ Dispatch ☐ Officer ☐ Officer Observed ☐ Other

HOW REPORTED: ☐ Phone/Radio ☐ EAS ☒ Person

Check Appropriate	1	LAST NAME	FIRST	M.I.	D.O.B.	RACE	SEX	ACIC	NCIC
								☐	☐
PRIMARY VICTIM	☐	ADDRESS	CITY		STATE	ZIP	PHONE / RES.		
PATIENT	☐								
EMPLOYEE	☐	Drivers LIC.	STATE	SSN	EMPLOYED BY		PHONE / BUS.		
OTHER	☐								

Check Appropriate	2	LAST NAME	FIRST	M.I.	D.O.B.	RACE	SEX	ACIC	NCIC
		N/A						☒	☒
PRIMARY SUSPECT	☐	ADDRESS	CITY		STATE	ZIP	PHONE / RES.		
PATIENT	☐								
EMPLOYEE	☐	DRIVERS LIC.	STATE	SSN	EMPLOYED BY		PHONE / BUS.		
OTHER	☐								

Check Appropriate	3	LAST NAME	FIRST	M.I.	D.O.B.	RACE	SEX	ACIC	NCIC
VICTIM	☐							☐	☐
WITNESS	☐	ADDRESS	CITY		STATE	ZIP	PHONE / RES.		
SUSPECT	☐								
PATIENT	☐	DRIVERS LIC.	STATE	SSN	EMPLOYED BY		PHONE / BUS.		
EMPLOYEE	☐								
OTHER	☐								

Check Appropriate	4	LAST NAME	FIRST	M.I.	D.O.B.	RACE	SEX	ACIC	NCIC
VICTIM	☐							☐	☐
WITNESS	☐	ADDRESS			STATE	ZIP	PHONE / RES.		
SUSPECT	☐								
PATIENT	☐	DRIVERS LIC.	STATE	SSN	EMPLOYED BY		PHONE / BUS.		
EMPLOYEE	☐								
OTHER	☐								

Check Appropriate	5	LAST NAME	FIRST	M.I	D.O.B.	RACE	SEX	ACIC	NCIC
VICTIM	☐							☐	☐
WITNESS	☐	ADDRESS			STATE	ZIP	PHONE / RES.		
SUSPECT	☐								
PATIENT	☐	DRIVERS LIC.	STATE	SSN	EMPLOYED BY		PHONE / BUS.		
EMPLOYEE	☐								
OTHER	☐								

P80

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
POLICE INCIDENT REPORT

INCIDENT REPORT # 2017-0000

Narrative: (Observations, evidence, statements, etc. *Type only to bottom line, use Supplement if needed*) **Photos Taken** ☐ **Yes** ☐ **No**

Assault on Peer	☐	Assault on Staff	☐	Abuse Hotline Contacted? ☐ YES ☐ NO			
Battery on Peer	☐	Battery on Staff	☐	Who Contacted?			
Patient Injury	☐	Staff Injury/Illness	☐	**(If Injured-Type)**		**(Treatment)**	
Self-Harm *Attempt* ☐	☐	Property Damage	☐	Bruise or Contusion	☐	Not Needed	☐
Suicide *Attempt* ☐	☐	Death	☐	Fracture or Break	☐	ASH	☐
Sexual Misconduct	☐	Elopement *Attempt* ☐	☐	Dislocation	☐	UAMS	☐
Threatening/Disorderly	☐	Contraband	☐	Abrasion / Laceration	☐	Other:	
Behavioral Emergency (Mr Stat)	☐	Medical Emergency (Dr Stat)	☐	Other Injury or Medical Condition(s):			

Law Enforcement Use of Force Continuum Level Used (Include Application of Force, as well as Justifying Circumstances in Report)

(Level 0) **Report** ☐ (Level I) **Presence** ☐ (Level II) **Verbal** ☐ (Level III) **Escort** ☐ (Level III) **Open Hand** ☐

(Level IV) **Equipment** ☐ Cuffs ☐ Shackles ☐ 6 Point Restraint Chair ☐ Other ☐

(Level V) Less Lethal Closed Hand ☐ Taser ☐ Chemical Agent ☐ Baton ☐ (Level VI) Deadly ☐

REPORTING OFFICER			REVIEWING SUPERVISOR			DISTRIBUTED TO
						☐ CHIEF / DESIGNEE
CALL #	DATE	☐ PATROL ☐ CID	CALL #	DATE	ADMIN	☐ CID
						☐ RISK MANAGEMENT
ENTERED IRIS ☐ YES ☐ NO IRIS #:						☐ HOSPITAL ADMINISTRATION

PSO

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
POLICE INCIDENT REPORT
LOSS AND RESTITUTION SUPPLEMENT

INCIDENT REPORT # 2017-

QUANTITY	DAMAGED OR STOLEN PROPERTY DESCRIPTION LIST SERIAL # / MODEL # / OTHER ID	CHECK			ESTIMATED $ VALUE
		DAMAGED	STOLEN	ACIC/NCIC	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	

PROPERTY DAMAGE ESTIMATED TOTAL VALUE $

STOLEN PROPERTY ESTIMATED TOTAL VALUE $

Property Related Details

PHOTOS TAKEN ☐ YES ☐ NO

#1: YEAR	MAKE	MODEL	COLOR	LIC. #	STATE	VIN

AMAGED ☐ IMPOUNDED ☐ ABANDONED ☐ STOLEN ☐ SUSPECT ☐ TOWED ☐

#2: YEAR	MAKE	MODEL	COLOR	LIC. #	STATE	VIN

AMAGED ☐ IMPOUNDED ☐ ABANDONED ☐ STOLEN ☐ SUSPECT ☐ TOWED ☐

REPORTING OFFICER		REVIEWING SUPERVISOR	
CALL #	DATE	CALL #	DATE

ERED IRIS ☐ YES ☐ NO IRIS #:

DISTRIBUTED TO

- ☐ CHIEF / DESIGNEE
- ☐ CRIMINAL INVESTIGATIONS
- ☐ RISK MANAGEMENT
- ☐ HOSPTIAL ADMINISTRATION

PSO

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
POLICE INCIDENT REPORT

SUPPLEMENTAL REPORT **INCIDENT #** **2017-**

STATUTE / CLASSIFICATION	NATURE OF INCIDENT	DATE OF REPORT
§ - - ☐A ☐B ☐C ☐D ☐Y ☐Misd ☐Fel		

TYPE OF SUPPLEMENT: ☐ Original ☐ Investigative ☐ Officer Statement CASE STATUS: OPEN ☐ CLOSED ☐ Date Closed:

REPORTING OFFICER & SIGNATURE			REVIEWING SUPERVISOR			DISTRIBUTED TO
CALL #	DATE	☐PATROL ☐CID ☐ADMIN	CALL #	DATE	ADMIN	☐ CHIEF / DESIGNEE ☐ CRIMINAL INVESTIGATIONS ☐ STATS / RECORDS ☐ RISK MANAGEMENT ☐ HOSPITAL ADMINISTRATION

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
POLICE INCIDENT REPORT

PHOTOGRAPHIC EVIDENCE FORM INCIDENT REPORT # 2017-

PE-	OFFICER TAKING PHOTO: CALL #:
DATE:	DESCRIPTION:
TIME:	

ONE PHOTO PER PAGE

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
POLICE INCIDENT REPORT
DOMESTIC VIOLENCE LEATHALITY SCREEN

Officer:	Date	Report/Incident # 2017-
Victim:	Offender:	☐ Arrested (If Not, Justify in Narrative)

☐ Check here if the victim did not answer any of these questions

A "Yes" response to any of the Questions #1-3 automatically triggers **protocol referral.**

1. Has the offender ever used a weapon against the victim or threatened the victim with a weapon?	Yes ☐	No ☐	☐ Not Ans.
2. Has the offender threatened to kill the victim or children of the victim?	Yes ☐	No ☐	☐ Not Ans.
3. Does the victim think the offender will try to kill the victim?	Yes ☐	No ☐	☐ Not Ans.

Negative responses to Questions # 1-3 but positive responses to at least four of Questions #4 – 13 trigger **protocol *referral***

4. Does the offender have a weapon or can he/she get one easily?	☐ Yes	☐ No	☐ Not Ans.
5. Has the offender ever tried to choke (strangle) the victim?	☐ Yes	☐ No	☐ Not Ans.
6. Is the offender violently or constantly jealous?	☐ Yes	☐ No	☐ Not Ans.
7. Does the offender control most of the daily activities of the victim?	☐ Yes	☐ No	☐ Not Ans.
8. Has the victim left/ separated from the offender after living together / being married?	☐ Yes	☐ No	☐ Not Ans.
9. Is the victim currently unemployed?	☐ Yes	☐ No	☐ Not Ans.
10. Is the offender currently unemployed?	☐ Yes	☐ No	☐ Not Ans.
11. Has the offender ever tried or made threats to kill himself/herself?	☐ Yes	☐ No	☐ Not Ans.
12. Does the victim have a child the offender believes is not his/her own child?	☐ Yes	☐ No	☐ Not Ans.
13. Does the offender follow, spy on the victim, or leave the victim threatening messages?	☐ Yes	☐ No	☐ Not Ans.

An officer may trigger the protocol referral, if not already triggered above, as a result of the victim's response to the below question, or whenever the officer believes the victim is in a potentially lethal situation.

14. Is there anything else that worries the victim about his / her safety and if so, what worries the victim?

Has Victim Been Provided Laura's Law Card ☐ **Yes** ☐ **No (If No , Justify In Narrative)** ☐ **Posted**

Check One:

- ☐ Victim screened in according to the protocol
- ☐ Victim screened in based on the belief of officer
- ☐ Victim did not screen in

If victim screened in: After advising the victim of high risk for danger/lethality, did the victim speak with the hotline advocate

- ☐ Yes
- ☐ No

If the victim is in need of immediate transportation, contact the (regional number)

Note: The above questions and the criteria for determining the level of risk a person faces is based on the best available research on factors associated with lethal violence by a current or former intimate partner. However, each situation may present unique factors that influence risk for lethal violence that are not captured by this screen. Although most victims who screen "positive" or "high danger" would not be expected to be killed, these victims face much higher risk than that of other victims of intimate partner violence.

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
POLICE INCIDENT REPORT

PHOTOGRAPHIC EVIDENCE FORM **INCIDENT REPORT # 2017-**
ONE PHOTO PER PAGE

PE-	OFFICER TAKING PHOTO: CALL #:
DATE:	DESCRIPTION:
TIME:	

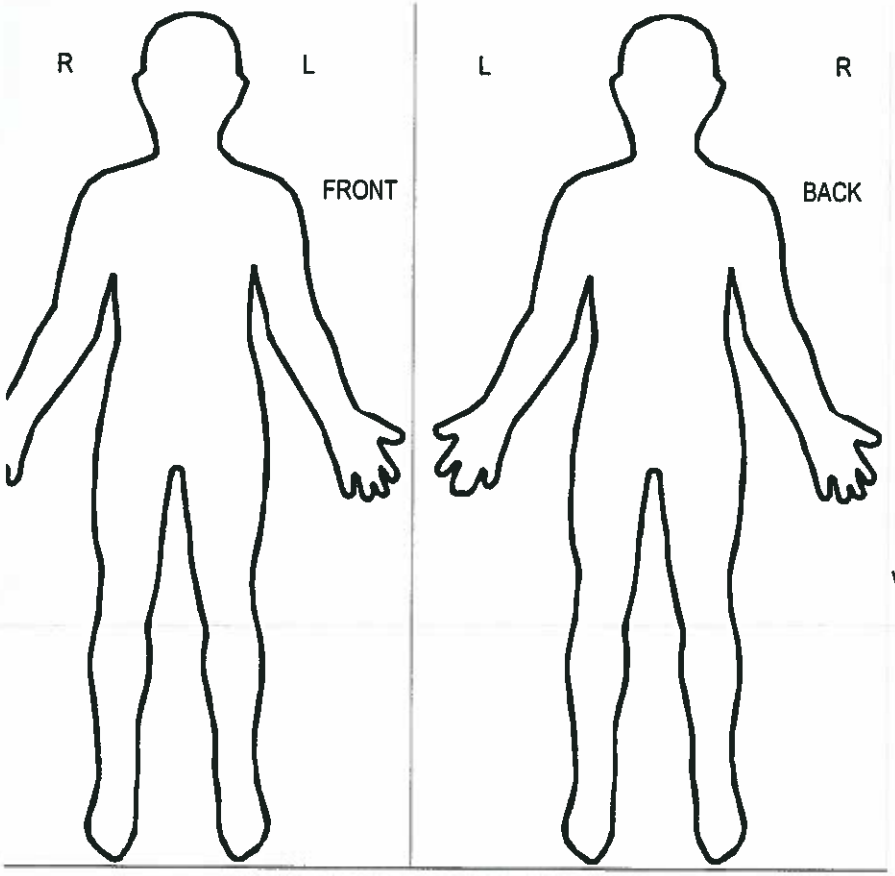
DSU

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
POLICE INCIDENT REPORT

Photographic Refusal Documentation Form

INCIDENT REPORT #

DATE:



INDICATE LOCATIONS OF INJURY IN INK

NAME: DOB:

ADDRESS:

PHONE:

X

VICTIM ☐ SUSPECT ☐

PATIENT ☐ STAFF ☐ OFFICER ☐

DESCRIPTION OF INJURIES:

DOCUMENTING OFFICER: CALL SIGN:

DSO

ARKANSAS STATE HOSPITAL
POLICE DEPARTMENT

VOLUNTARY STATEMENT

INCIDENT#_____

I hereby voluntarily and of my own free will make this statement without having been subjected to any coercion; unlawful influence, or unlawful inducement. By signing, I swear or affirm that the information I have provided is true and correct to the best of my knowledge.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I am the victim YES ☐ NO ☐ **it is my intentions to seek criminal charges in this matter. YES ☐ NO ☐**

SIGNATURE: _____ **DATE:**_____

PRINTED NAME_____ **PHONE #:**_____

ADDRESS _____

OFFICER: _____ **CALL #**_____ **WITNESS:**_____

PSO

ARKANSAS STATE HOSPITAL
POLICE DEPARTMENT

Hospital estatal de Arkansas
Departamento de Policía

VOLUNTARY STATEMENT

Declaración voluntaria

INCIDENT#_____

I hereby voluntarily and of my own free will make this statement without having been subjected to any coercion; unlawful influence, or unlawful inducement. By signing, I swear or affirm that the information I have provided is true and correct to the best of my knowledge.

I por este medio voluntariamente y de mi propio libre albedrío hace esta declaración sin ser sujetado a cualquier coerción; influencia ilegal, o estímulo ilegal. Firmando, juro o afirmo que la información que he proporcionado está verdad y correcta al mejor de mi conocimiento.

I am the victim YES ☐ NO ☐ **it is my intentions to seek criminal charges in this matter.** **YES ☐ NO ☐**

Soy la víctima: Sí ☐ No ☐ Es mis intenciones buscar cargos criminales en esta materia: Sí ☐ No ☐

SIGNATURE: _____ **DATE:**_____
Firma: ***Fecha:***

PRINTED NAME_____ **PHONE #:**_____
Nombre impreso ***Teléfono:***

ADDRESS _____
Dirección:

OFFICER: _____**CALL #**_____**WITNESS:**_____

D50

Page ___ of ___

ARKANSAS MOTOR VEHICLE CRASH REPORT

(Rev. 1/07)

Report # _____ Unit Assigned ____ Premises ____ Lat/Long _____ District ____

Mo/Day/Yr	Day of Week	Time Of Crash ☐ AM ☐ PM	No. Of Vehicles	Time Notified ☐ AM ☐ PM	Time Arrived ☐ AM ☐ PM	Hit & Run ☐ Yes ☐ No	Direction Of Travel V# ___ ___ V# ___ ___	Official Use Only

County	City	Not In City, But ____ Distance ____ Direction Of _____ City Limits	Speed Limit

Road / Street / Highway	Section	Log Mile	At Intersection With	Posted ☐ Yes ☐ No

Not At Intersection, But ____ Distance ☐ N ☐ S ☐ E ☐ W _____ Reference Point

VEHICLE # ___ (PEDESTRIAN # ___)

Also Complete Truck and Bus Crash Report for each qualifying vehicle, if crash involves fatality, injury or tow.

Driver's Name (First/MI/Last Name)	Inj. Code

Address	SafetyEquip	Air Bag	Eject

City	State	Zip Code

Additional Information

DOB	Race	Sex	Driver's License State ____ Class ____ # _____ End. ____

Test Blood Breath Urine Toxicology None Req.
Req ☐ ☐ ☐ ☐ Results: ____ ☐

Vehicle Owner's Name (First/MI/Last Name)

Address

City	State	Zip Code

Vehicle Description Year ____ Make _____

Model _____ Body Style _____ Color _____

Vehicle Identification Number	Estimated Damage

Vehicle License Plate ☐ None

Year _____ State _____ Number _____

Trailers ☐ Yes ☐ No	# Of Units	Reg. State	Plate #

Prior Vehicle Damage? ☐ Yes ☐ No If Yes, Describe Damage & Location

Vehicle Damage As Result Of Crash
☐ Disabled ☐ Other Damage ☐ Functional ☐ No Damage

Towed? ☐ Yes ☐ No Name of Tow Service

Address Vehicle Removed To

City	State	Zip Code

Additional Information

Insurance Company	Policy #

EMS Notified ____ ☐ AM ☐ PM Transported By
EMS Arrived ____ ☐ AM ☐ PM
☐ No Injury/Transport

Injured Transported To (Hospital Name/City/State)

VEHICLE # ___ (PEDESTRIAN # ___)

Also Complete Truck and Bus Crash Report for each qualifying vehicle, if crash involves fatality, injury or tow.

Driver's Name (First/MI/Last Name)	Inj. Code

Address	SafetyEquip	Air Bag	Eject

City	State	Zip Code

Additional Information

DOB	Race	Sex	Driver's License State ____ Class ____ # _____ End. ____

Test Blood Breath Urine Toxicology None Req.
Req ☐ ☐ ☐ ☐ Results: ____ ☐

Vehicle Owner's Name (First/MI/Last Name)

Address

City	State	Zip Code

Vehicle Description Year ____ Make _____

Model _____ Body Style _____ Color _____

Vehicle Identification Number	Estimated Damage

Vehicle License Plate ☐ None

Year _____ State _____ Number _____

Trailers ☐ Yes ☐ No	# Of Units	Reg. State	Plate #

Prior Vehicle Damage? ☐ Yes ☐ No If Yes, Describe Damage & Location

Vehicle Damage As Result Of Crash
☐ Disabled ☐ Other Damage ☐ Functional ☐ No Damage

Towed? ☐ Yes ☐ No Name of Tow Service

Address Vehicle Removed To

City	State	Zip Code

Additional Information

Insurance Company	Policy #

EMS Notified ____ ☐ AM ☐ PM Transported By
EMS Arrived ____ ☐ AM ☐ PM
☐ No Injury/Transport

Injured Transported To (Hospital Name/City/State)

DSA

Page ___ of ___ Report Number: _____

Vehicle # _____ Point Of Initial Contact	Vehicle # _____ Point Of Initial Contact
☐ ☐ ☐ Trailer - Top ☐ > ☐ ☐ ☐ ☐ Undercarriage	☐ ☐ ☐ Trailer - Top ☐ > ☐ ☐ ☐ ☐ Undercarriage
☐ ☐ ☐ - Top ☐ > ☐ ☐ ☐ ☐ Undercarriage	☐ ☐ ☐ - Top ☐ > ☐ ☐ ☐ ☐ Undercarriage

Damage To Property Other Than Vehicle ☐ Yes ☐ No	Object Struck	Owner's Name	Damage Estimate $
		Address (City/State/Zip Code)	Owner Notified ☐ Yes ☐ No

Witness Name(s) (First/MI/Last Name)	Address (City/State/Zip Code)

Citation(s) Issued To (First/MI/Last Name)	Charge(s) And Statute Number(s)	Citation Number

Narrative

Officer's Name (Rank/First/MI/Last Name)	Badge No.	Department	Reviewing Officer	Date Filed	Photos ☐ Yes ☐ No

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Page ___ of ___ Report Number

ATMOSPHERIC CONDITIONS
0 Clear; 1 Rain; 2 Sleet; 3 Snow; 4 Fog; 5 High Winds; 6 Smoke; 7 Smog; 8 Dust; 9 Mist; 98 Other; 99 Unknown

RELATION TO JUNCTION
0 Non-Junction; 1 Intersection; 2 Intersection Related; 3 Driveway; 4 Alley; 5 Exit Lane; 6 Entrance Lane; 7 R.R. Crossing; 8 Crossover Lane; 98 Other; 99 Unknown

LIGHT CONDITIONS
1 Daylight; 2 Dark; 3 Dawn; 4 Dusk; 5 Dark But Lighted; 6 Dark Light Not Functional; 98 Other; 99 Unknown

TRAFFIC CONTROLS
0 No Traffic Controls; 1 Flashing Beacon; 2 Traffic Signal; 3 Stop Sign; 4 Yield Sign; 5 R.R. Crossing W Gate & Signals; 6 R.R. Crossing W Flashing Signals Only; 7 R.R. Crossing W Crossbuck Only; 8 School Zone; 9 Pedestrian Signal; 10 Lane Symbols Painted on Roadway; 11 Traffic Lanes Marked; 12 No Passing Signal; 13 Slow Or Warning Sign; 14 Officer Or Flagman; 98 Other; 99 Unknown

ACCIDENT LOCALE
1 Rural; 2 Urban; 99 Unknown

ROADWAY SURFACE CONDITION
1 Dry; 2 Wet; 3 Ice; 4 Sand; 5 Dirt; 6 Oil; 98 Other; 99 Unknown

TRAFFIC CONTROL DEVICE
0 Device Not Present; 1 Device Not Functioning; 2 Device Functioning Properly; 3 Device Not Functioning Properly

ROAD SYSTEM
1 Interstate; 2 U S Highway; 3 State Highway; 4 County Road; 5 City Street; 6 Frontage Road; 7 Ramp; 99 Unknown

TYPE OF COLLISION
0 Single Vehicle / Non Collision With Motor Vehicle In Transport; 1 Head On; 2 Rear End; 3 Angle; 4 Sideswipe Same Direction; 5 Sideswipe Opp. Direction; 6 Backing; 98 Other

ROAD SURFACE
1 Concrete; 2 Asphalt; 3 Gravel; 4 Dirt; 98 Other; 99 Unknown

CONTRIBUTING FACTORS
0 None; 1 Too Fast For Conditions; 2 Failure to Yield; 3 Driving Without Lights; 4 Failure To Dim Headlights; 5 Disregard Stop Sign; 6 Disregard Yield Sign; 7 Disregard Traffic Signal; 8 Wrong Side Of Road; 9 Wrong Way One Way Traffic; 10 Following Too Close; 11 Improper Right Turn; 12 Improper Left Turn; 13 Improper Lane Change; 14 Improper Passing; 15 Prohibited U Turn; 16 Defective Lights; 17 Defective Brakes; 18 Other Defective Equipment; 19 Improper Backing; 20 Failure Or Improper Signal; 21 Disregard Officer Flagman; 22 Cutting In; 23 Impeding Traffic; 24 Improperly Parked; 25 Crowded Off Road; 26 Alcohol; 27 Drugs; 28 Careless/Prohibited Driving; 29 Crossing Median; 98 Other; 99 Unknown

ROAD ALIGNMENT
1 Straight; 2 Curve

ROAD PROFILE
1 Level; 2 Grade; 3 Hillcrest; 4 Sag; 98 Other; 99 Unknown

CONSTRUCTION/MAINTENANCE ZONE
1 Yes; 2 No

VEHICLE ACTION
1 Going Straight; 2 Negotiating Curve; 3 Slowing; 4 Stopped In Traffic Lane; 5 Merging; 6 Enter Parked Position; 7 Exiting Parked Position; 8 Parked; 9 Making Right Turn; 10 Making Right Turn On Red; 11 Making Left Turn; 12 Making Left Turn On Red; 13 Making U Turn; 14 Backing; 15 Avoiding Vehicle; 16 Avoiding Pedestrian; 17 Avoiding Animal; 18 Avoiding Other Object; 19 Passing; 20 Changing Lanes; 21 Ran Off Road-Right; 22 Ran Off Road-Left; 23 Crossing Median; 98 Other; 99 Unknown

TRAFFIC FLOW
1 Not Divided; 2 Divided By Median – No Barrier; 3 Divided By Perm. Barrier; 4 Divided By Temp. Barrier; 5 One Way Traffic; 98 Other; 99 Unknown

NUMBER OF TRAFFIC LANES
1 1; 2 2; 3 3; 4 4; 5 5; 6 6; 7 7; 8 8

FIRST HARMFUL EVENT COLLISION WITH / NON COLLISION
1 Pedestrian; 2 Pedacycle; 3 Train; 4 MV in Transport; 5 MV In Other Roadway; 6 Parked Vehicle; 7 Animal; 8 Other Object Not Fixed; 9 Unknown Obj. Not Fixed; 10 Overturned; 11 Fire; 12 Immersion; 13 Fell From Vehicle; 14 Jackknife; 15 Bank or Ledge; 16 Tree(s); 17 Utility Pole; 18 Fence or Fence Post; 19 Guard Rail or Post; 20 Bridge or Underpass; 21 Sign/Traffic Signal; 22 Impact Cushion Device; 23 House/Building; 24 Light/Luminary Pole; 25 Concrete Barrier; 26 Culvert/Ditch; 27 Bridge Rail; 28 Other Fixed Object; 98 Other; 99 Unknown

ROADWAY DEFECTS
0 No Defects; 1 Obstruction Warning; 2 Obstruction No Warning; 3 Loose Materials On Surface; 4 Holes; 5 Ruts; 6 Bumps; 7 Defective Shoulder; 8 No Markings; 9 Reduced Width; 98 Other; 99 Unknown

DRIVER DISTRACTION
0 Not Distracted; 1 Electronic Communication Device (cell phone, pager, etc.); 2 Other Electronic Device (navigation device, palm pilot, etc.); 3 Other Inside the Vehicle; 4 Other Outside the Vehicle; 99 Unknown

FIRST HARMFUL EVENT LOCATION
1 On Roadway; 2 Shoulder; 3 Median; 4 Roadside; 5 Outside Traffic Way; 99 Unknown

OCCUPANCY
0 Non-Motorist; 1-999 Vehicle Number of Occupant

POSITION IN/ON VEH
10; X 2 3; 10 4 5 6 10; 7 8 9; 10
10 Riding Or Hanging Outside; 11 Bed Of Pickup; 12 Trailing Unit; 13 Sleeper Section; 98 Other Enclosed; 99 Unknown

INJURY CODE
1 Fatal Injury; 2 Incapacitating Injury; 3 Non-Incapacitating Injury; 4 Possible Injury; 5 No Injury/Property Damage Only

FIRE OCCURRENCE
0 No Fire Occurrence; 1 Fire Occurrence

DRIVER VISION OBSCURED
0 Not Obscured; 1 Rain/Snow/Sleet On Windshield; 2 Fog; 3 Sunlight; 4 Headlights; 5 Building; 6 Billboard; 7 Trees/Shrub/ Etc; 8 Parked Vehicle(s); 9 Moving Vehicle(s); 10 Broken Windshield; 11 Dirty Windshield; 12 Obscured By Vehicle Load; 13 Hillcrest; 98 Other; 99 Unknown

SAFETY EQUIPMENT USED
0 None Used; 1 Shoulder Belt; 2 Lap Belt; 3 Lap & Shoulder Belt; 4 Child Restraint; 7 Helmet; 8 Helmet W/Face shield; 9 Eye Protection; 98 Other; 99 Unknown

VEHICLE DEFECTS
0 No Defects; 1 Defective Lights; 2 Defective Brakes; 3 Defective Steering; 4 Worn/Slick Tires; 5 Motor Trouble; 6 Windshield/Mirrors; 98 Other; 99 Unknown

AIR BAG
0 Not Applicable; 5 Deployed Air Bag; 6 No Air Bag Deployment

PEDESTRIAN ACTION/LOCATION
1 Crossing At Intersection With Signal; 2 Crossing At Intersection Against Signal; 3 Crossing At Intersection No Signal; 4 Crossing At Intersection Diagonally; 5 Crossing Not At Intersection/Rural; 6 Crossing Not at Intersection/Urban; 7 Coming from Behind Parked Car; 8 Unloading/Loading on School Bus; 9 Playing in Roadway; 10 Unloading/Loading on Other; 11 Lying in Roadway; 12 Walking on Roadway with Traffic/ Sidewalks Available; 13 Waling On Roadway With Traffic/ Sidewalks Not Available; 14 Walking On Roadway Against Traffic/ Sidewalks Available; 15 Walking On Roadway Against Traffic/ Sidewalks Not Available; 16 Working In Roadway; 17 Standing In Roadway; 18 Not In Roadway; 98 Other; 99 Unknown

CONDITION OF DRIVERS AND PED
1 Appeared Normal; 2 Illness; 3 Fatigue; 4 Fell Asleep; 5 Physical Disability / Disease/Disorder; 6 Mental Disability / Disease/Disorder; 7 Defective Sight; 8 Defective Hearing; 9 Seizure / Blackout; 98 Other; 99 Unknown

EJECTION FROM VEHICLE
0 Not Ejected; 1 Totally Ejected; 2 Partially Ejected; 99 Unknown

ALCOHOL/ DRUGS IMPAIRMENT
1 None; 2 Impaired; 3 Not Impaired; 4 Unknown

PASSENGER/PEDESTRIAN

13	14	15	16	17	18 Race	19 Sex	20 Age	21	22	23 Name Of Passenger(s)/Pedestrian(s) Address, City, State, Zip Code

V1 V2 V1 V2 V1 V2 V1 V2 V1 V2 V1 V2 V1 V2 Ped V1 V2 Ped

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Page ___ of ___

DIAGRAM

Report Number _____

☐ Check this box if diagram depicted is from driver/witness statements and/or vehicles were moved prior to investigators arrival.

Indicate North by Arrow

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Page ____ of ____	**Reporting Criteria for Truck and Bus Crashes**	**Report Number** _____

COMPLETE THIS REPORT FOR EACH OF THE FOLLOWING INVOLVED VEHICLES:

1. Any truck having a gross vehicle weight rating (GVWR) of more than 10,000 pounds or a gross combination weight rating (GCWR) over 10,000 pounds used on public highways,
2. Any motor vehicle with seats to transport nine (9) or more people, including the driver's seat,
3. Any vehicle displaying a hazardous materials placard (regardless of weight).

AND THIS CRASH INCLUDES:

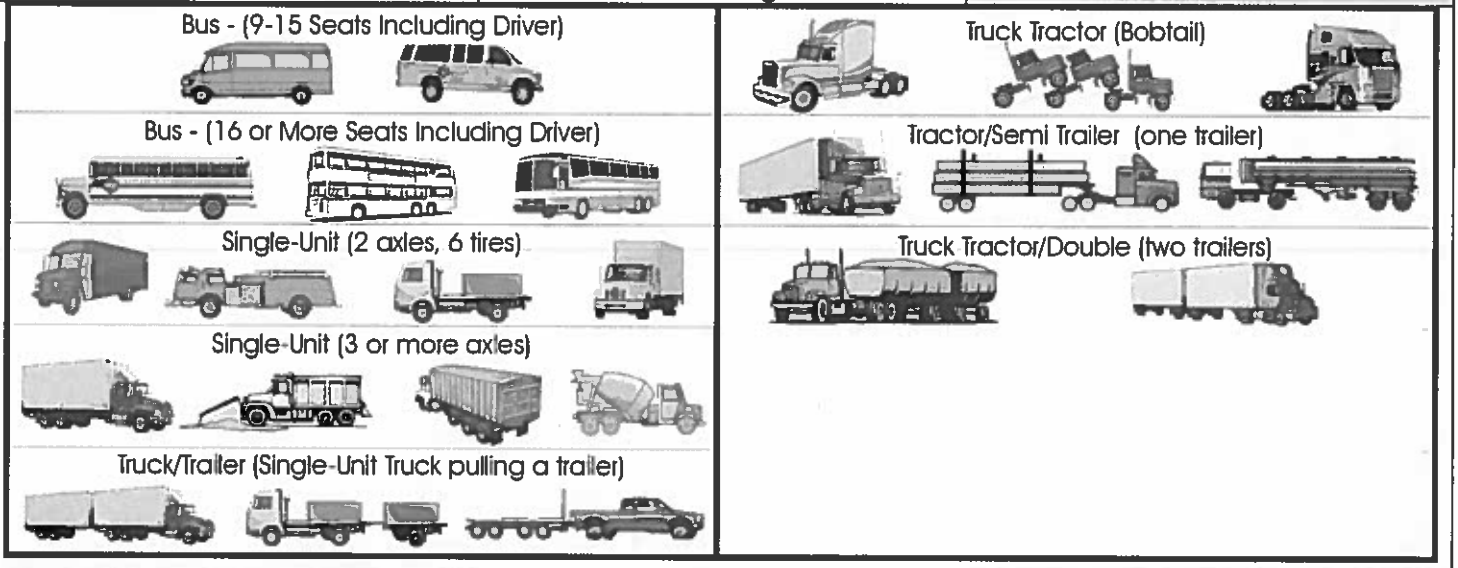
at least one motor vehicle in-transport operating on a trafficway open to the public, which results in:

A FATALITY: Any person(s) killed in or outside of any vehicle (truck, bus, car, etc.) involved in the crash or who dies within 30 days of the crash as a result of an injury sustained in the crash, **OR**

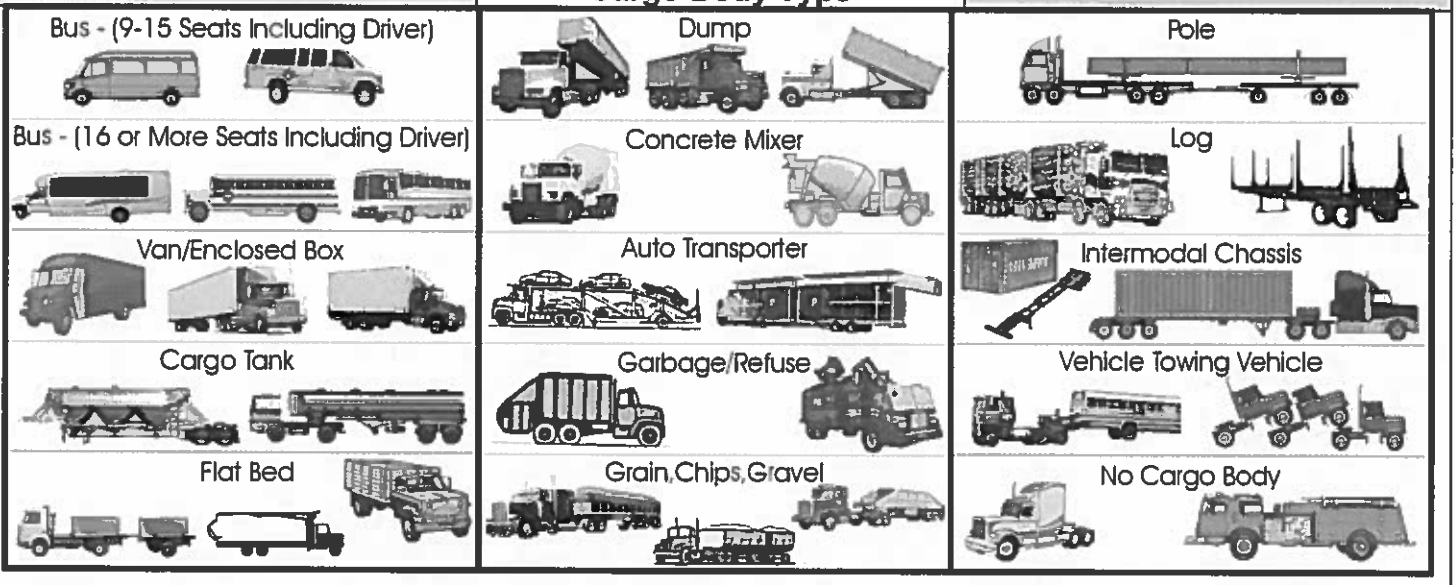
AN INJURY: Any person(s) injured as a result of the crash who immediately receives medical treatment away from the crash scene, **OR**

A TOW-AWAY: Any motor vehicle (truck or truck combination, bus, car, etc.) disabled as a result of the crash and transported away from the scene by a tow truck or other vehicle.

Vehicle Configuration



Cargo Body Type



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Page _____ of _____

State of Arkansas
Truck and Bus Crash Report

Report No. _____

Driver Name _____

General Instructions - Complete this form for **EACH** qualifying vehicle if the crash meets the criteria on the previous page.

Qualifying Information

Check all that apply:

This form is being completed because this vehicle is:

- ☐ A truck or truck combination > 10,000 lbs. GVWR/GCWR
- ☐ A bus with seats for 9 or more persons, including driver
- ☐ A vehicle of any type with a hazardous materials placard (includes auto, light truck, van, 10,000 lbs. or less)

Number of:	
Total involved vehicles in the crash:	
Persons sustaining fatal injuries:	
Injured persons transported for **immediate** medical treatment:	
Vehicles towed from scene due to **disabling damage**:	

At the Time of the Crash, THIS Vehicle was:

☐ Operating on a Trafficway open to the public (In-Transport) ☐ Parked on or off the Trafficway

Vehicle Information

Vehicle Configuration: ☐ (enter one code from below)

1 Passenger Car (only if vehicle has Hazardous Materials Placard)
2 Light Truck (only if vehicle has Hazardous Materials Placard)
3 Bus (seats for 9-15 people, including driver)
4 Bus (seats for 16 people or more, including driver)
5 Single-Unit Truck (2 axles, 6 tires)
6 Single-Unit Truck (3 or more axles)
7 Truck/Trailer(s) [Single-Unit Truck with Trailer(s)]
8 Truck/Tractor (without trailer, bobtail or saddlemount)
9 Tractor/Semi-Trailer (one trailer)
10 Tractor/Doubles (two trailers)
11 Tractor/Triples (three trailers)
99 Other Truck >10,000 lbs. (not listed above)

GVWR/GCWR (use GCWR for truck combinations): ☐

1 10,000 lbs. or Less
2 10,001 – 26,000 lbs.
3 Greater than 26,000 lbs.

Bus Use: ☐

0 Not a Bus
1 School (Public or Private)
2 Transit
3 Intercity
4 Charter
5 Other

Cargo Body Type: ☐ (enter one code from below)

0 Not Applicable/No Cargo Body
1 Bus (seats for 9-15 people, including driver)
2 Bus (seats for 16 people or more, including driver)
3 Van/Enclosed Box
4 Cargo Tank
5 Flatbed
6 Dump
7 Concrete Mixer
8 Auto Transporter
9 Garbage/Refuse
10 Grain, Chips, Gravel
11 Pole
12 Vehicle Towing Another Motor Vehicle
13 Intermodal Chassis
14 Logging
98 Other Cargo Body (not listed above)

Hazardous Materials Involvement:

Did the vehicle have a Haz Mat Placard? ☐ YES ☐ NO

If YES, include the following information from the Placard:

HM 4-Digit # or name from diamond or box: _____

HM Class # from bottom of diamond: _____

Was Haz Mat released from THIS vehicle's cargo? ☐ YES ☐ NO

Motor Carrier Information

Check One:

☐ Interstate Carrier ☐ Intrastate Carrier ☐ Not In Commerce-Government ☐ Not In Commerce-Other Trucks (Over 10,000 lbs. GVWR/GCWR)

Carrier Name: _____

Carrier Street Address (P.O. Box only if no street address): _____

City/State/Zip: _____ Phone #: _____

Carrier Identification Number(s): NONE ___ USDOT# _____ MC/MX# _____ State# _____

Sequence of Events

Note: For **THIS** vehicle - list up to four: Event 1 ☐ Event 2 ☐ Event 3 ☐ Event 4 ☐

Non-Collision

1 Ran Off Road
2 Jackknife
3 Overturn (Rollover)
4 Downhill Runaway
5 Cargo Loss or Shift
6 Explosion or Fire
7 Separation of Units

Non-Collision (cont.)

8 Cross Median/Centerline
9 Equipment Failure (tire, brakes, steering, etc.)
10 Non-Collision, Other
11 Non-Collision, Unknown

Collision Involving/With

12 Pedestrian
13 Motor Vehicle In-Transport
14 Parked Motor Vehicle

Collision Involving/With (cont.)

15 Train
16 Pedacycle
17 Animal
18 Fixed Object
19 Work Zone Maintenance Equipment
20 Other Moveable Object
98 Other (Describe) _____

Officer Signature	Officer Badge #	Reporting Agency	Date of Report

D82

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

NURSING DAILY FLOW SHEET and ASSESSMENT

PATIENT ID LABEL

NOTE: Record narrative, if any, on a separate progress note sheet, in the Progress Notes section of the chart.

Unit: _____ Date: _____ ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Primary problem: **Food allergies:**

Sleep Assessment: 7P – 7A

[7P – 7A shift completes this section]

Hours slept (estimate) _____

Comments:

_____

_____

_____

Dietary Intake

Meal / Time	Observed Yes	Observed No	MISSED Meal / Snack	REFUSED Meal / Snack	Replacement Meal / Snack	SACK Meal	% Eaten	Staff Initials
Breakfast	☐	☐	☐	☐	☐	☐		
Snack -- AM	☐	☐	☐	☐	☐	☐		
Lunch	☐	☐	☐	☐	☐	☐		
Snack -- PM	☐	☐	☐	☐	☐	☐		
Dinner	☐	☐	☐	☐	☐	☐		
Snack -- HS	☐	☐	☐	☐	☐	☐		

Diet: _____

Missed meal: write progress note; Refusal ***isn't*** a missed meal.

BAND
- ☐ White band
- ☐ Yellow band
- ☐ Green band
- ☐ Red band
- ☐ Blue band
- ☐ N/A new admit

PRECAUTION
- ☐ Blood and body fluid
- ☐ Choking
- ☐ Elopement
- ☐ Fall
- ☐ Seizure (precautions)
- ☐ Suicide (precautions)
- ☐ Other: _____

RESTRICTION
- ☐ Behavior plan
- ☐ ITP
- ☐ Study hall
- ☐ Unit restrict
- ☐ Ward restrict (Forensic)
- ☐ Other: _____

MISCELLANEOUS
- ☐ Encopresis
- ☐ Enuresis
- ☐ Other: _____

OBSERVATION
- ☐ Line of sight
- ☐ One to one 1:1

Day	Print name, title	Initials	Night	Print name, title	Initials
7A-7P			7P-7A		
7A-7P			7P-7A		
7A-7P			7P-7A		

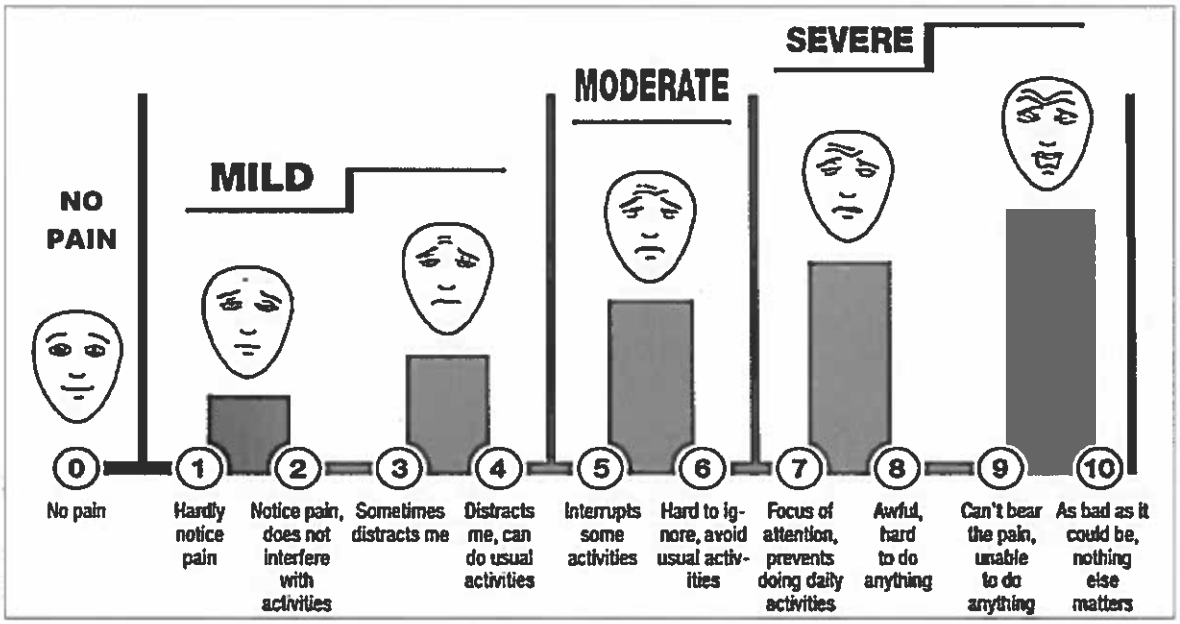
PAIN SCALE

Document terms used:

- NO PAIN
- MILD
- MODERATE
- SEVERE

Make note of the number rating under the term used.

May use language of number rating.



Nursing

Initials under Day or Night: Day = 7A-7P; Night = 7P-7A		
Day	*Night*	*ASSESSMENT*
		APPEARANCE – *Physical Presentation*
		Grooming is neat and clean
		Inappropriate dress
		Poor hygiene / requires prompts
		SENSORIUM / COGNITION
		Oriented to person
		Oriented to place
		Oriented to time
		Oriented to situation
		Difficulty with processing information
		Exhibits poor judgment
		Expresses insight into mental illness
		SAFETY
		Self-harm statements or threats
		Self-harm gestures; attempt; requires intervention
		Aggressive threats or gestures towards others
		THOUGHTS / PATTERNS
		Loose associations
		Word salad
		Flight of ideas (rapid thoughts)
		Obsessions (persistent thoughts)
		Disorganized thinking
		Expresses delusional ideation
		Concrete (literal) thinking
		Expresses paranoid ideation
		Ideas of reference
		PERCEPTIONS
		Auditory hallucinations
		Visual hallucinations
		Tactile hallucinations
		Olfactory hallucinations
		Responding to internal stimuli

Initials under Day or Night: Day = 7A-7P; Night = 7P-7A		
Day	*Night*	*ASSESSMENT*
		BEHAVIOR
		Interacts well with peers
		Isolates from others
		Repetitive movements or ritualistic behaviors
		Requires frequent re-direction
		Intrusive or disruptive
		Hyperactive
		Hypoactive
		Hyper-talkative
		MOOD / AFFECT
		Elevated Mood/ Mania
		Makes Grandiose Statements
		Expresses feelings of anxiety
		Expresses feelings of sadness
		Affect not congruent with situation
		Bizarre (odd, abnormal)
		Labile (changing expressions)
		Flat (no expression)
		Blunted (little expression)
		Apathetic (indifferent)
		Euphoric (exaggerated happiness)
		PHYSICAL
		Physical complaints / symptoms (write progress note)
		Involuntary movements
		Pain (write progress note – use Pain Scale on pg. 1)
		MEDICATION – Med Nurse
		Adverse drug reaction (If Yes, write progress note)
		Started new medication (Progress note w/in 1st 4-hrs)
		Refused medication (name med in progress note)
		TX TEAM REVIEWED / UPDATED MTP
		☐ Yes ☐ No
		PROGRESS TODAY
		Positive
		Negative
		Mixed

DAY	Print Name, Title	Initials
7A-7P		
7A-7P		
7A-7P		
7A-7P		

NIGHT	Print Name, Title	Initials
7P-7A		
7P-7A		
7P-7A		
7P-7A		

24 Hour Chart Check - 7 Day –

Chart checker shall correct deficiencies if possible during chart check. If not possible, the responsible party must correct at the first opportunity.
Note deficiencies in the boxes below by your initials. Describe deficiencies on Page 2 (back side).

Unit: _____ Patient's Initials: _____ Medical Record #: _____ Admit Date: _____

SUN	MON	TUE	WED	THU	FRI	SAT	No.	Items to check:
Nos. 1 thru 9 - New admissions only, and current patients needing Re-Assessments for Choking, Fall, Pain, Trauma, Suicide Risk								
							1	Initial Tx Plan compl w/in 8 hours of admission
							2	Master Treatment Plan w / Nursing Care Plan(s)
							3	History and Physical - each page labeled
							4	Choking assessment / re-Assessment
							5	Fall assessment / re-Assessment
							6	Pain assessment / re Assessment
							7	Trauma assessment / re-Assessment
							8	Suicide risk assessment / re-Assessment
							9	Admission medication reconciliation completed
Nos. 10 - 26 - All patients (new admissions and current patients)								
							10	ALLERGIES noted as required
							11	Orders transcribed, copy sent to Pharmacy
							12	Orders signed by physician
							13	Unsigned orders flagged for physician's signature
							14	Read-back of Tel Orders - complete, noted, signed
							15	Seclusion, Restraint Orders signed w/in 24 hours
							16	Non-S/R orders signed w/in # hours permitted by policy
							17	All special observation orders (when indicated) are obtained
							18	All special observation re-orders obtained w/in 24 hours
							19	First Response to medication documented for all new meds
							20	Consults ordered
							21	Signed labs in chart
							22	24 hour nursing assessment completed each shift
							23	Daily and weekly nursing notes completed
							24	Daily or weekly PIR notes include progress of + / - / 0
							25	Weights, vital signs completed & documented
							26	Meals documented
							<==Chart checker's initials	

Nursing

_____ _____ _____ _____ _____ _____

Chart checker's name (print) Initials Chart checker's name (print) Initials Chart checker's name (print) Initials

24 Hour Chart Checks - 7 Day (Deficiencies) _____ through _____ Admit Date: _____

Unit: _____ Patient's Initials: _____ Medical Record #: _____

Describe any deficiencies checked on first page				Corrected?	
Date	Day	Initials	Describe deficiency	Yes	No

Nursing

Body Mass Index Table

(From National Heart, Lung and Blood Institute)

	Normal						Overweight					Obese										Extreme Obesity																
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (Inches)	**Body Weight (pounds)**																																			
58 = 4'10"	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59= 4'11"	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60= 5'	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61= 5'1"	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62= 5'2"	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63= 5'3"	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64= 5'4"	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65= 5'5"	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66= 5'6"	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67= 5'7"	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68= 5'8"	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69= 5'9"	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70= 5'11"	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71= 5'12"	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72= 6'	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73= 6'1"	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74= 6'2"	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75= 6'3"	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76= 6'4"	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.*

Nursing

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NURSING ADMISSION AND ASSESSMENT SUMMARY | **PATIENT ID LABEL**

Admission from: ☐ Home ☐ DYS ☐ JDC ☐ DCFS ☐ Jail Other: _____
Source(s) of information about patient: ☐ SPOE ☐ Patient ☐ Other _____
If Other, relationship to patient: _____
Presenting problem(s) for admission:

_____
_____
_____
_____

Allergies: Food[1] – Drug - Other Reactions

Name _____ _____
Name _____ _____
Name _____ _____
Name _____ _____

[1]Food allergies: fax this sheet to 686-9274, Nutrition Services

Vital Signs and BMI
Blood pressure: _____
Pulse: _____ Respiratory: _____
Temperature: _____ BMI: _____
Height: _____ Weight: _____
Waist measurement: _____

MEDICAL HISTORY AND ASSESSMENT

• Neurological	Yes	Denies
1. Fainting / dizzy spells	☐	☐
2. Seizures	☐	☐
3. Numbness	☐	☐
4. Weakness	☐	☐
5. Tingling	☐	☐
6. Headaches	☐	☐
7. Speech impairment	☐	☐
8. Neurocognitive Disorder	☐	☐
9. Other: _____		

• Ears	Yes	Denies
1. Hearing impaired	☐	☐
2. Infection	☐	☐
3. Pain	☐	☐
4. Tinnitus	☐	☐
5. Other: _____		

• Nutritional	Yes	Denies
[NOTE: Patient is at risk if any of the following is checked Yes]		
1. Diagnosis of diabetes	☐	☐
2. History of eating disorder	☐	☐
3. Abnormal BMI range	☐	☐
4. Eats only one meal or less a day	☐	☐
5. Pregnant	☐	☐
6. Hypertension & / or heart disease	☐	☐
7. Difficulty chewing & / or swallowing	☐	☐
8. Signif. weight change in past 3mo	☐	☐
9. Food Allergies Noted	☐	☐

☐ Patient is within normal limits; no nutritional issues
☐ **Patient meets criteria for nutritional assessment; ward order written for dietary consult.** ☐ ☐

• Eyes	Yes	Denies
1. Vision impaired	☐	☐
2. Cataracts	☐	☐
3. Glaucoma	☐	☐
4. Last eye exam: _____		
5. Other: _____		

• Nose	Yes	Denies
1. Bleeding	☐	☐
2. Sinus infection	☐	☐
3. Sinusitis	☐	☐
4. Other: _____		

• Throat / Mouth Problems	Yes	Denies
1. Dental pain	☐	☐
2. Soreness	☐	☐
3. Strep throat	☐	☐
4. Gums bleeding when brushing	☐	☐
5. Cavities	☐	☐
6. Last dental exam: _____		
7. Other: _____		

• Cancer	Yes	Denies
1. Diagnosed or treated for cancer?	☐	☐
2. Describe: _____		

HISTORY

• Infectious diseases	Yes	Denies
1. Scabies	☐	☐
2. Chicken pox	☐	☐
3. German measles	☐	☐
4. Measles	☐	☐
5. Mumps	☐	☐
6. Other: _____		

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NURSING ADMISSION AND ASSESSMENT SUMMARY

PATIENT ID LABEL

MEDICAL HISTORY AND ASSESSMENT (CONTINUED)

• Cardiovascular	Yes	Denies
1. Shortness of breath	☐	☐
2. Arrhythmias / dysrhythmias	☐	☐
3. Chest pain	☐	☐
4. Congenital heart problems	☐	☐
5. Hypertension	☐	☐
6. Ankle swellings	☐	☐
7. Rheumatic fever	☐	☐
8. Heart disease	☐	☐
9. Stroke	☐	☐
10. Other: _____		

• Gastrointestinal	Yes	Denies
1. Bleeding	☐	☐
2. Nausea / vomiting	☐	☐
3. Diarrhea	☐	☐
4. Heartburn / Ulcers	☐	☐
5. Constipation	☐	☐
6. Ulcers	☐	☐
7. Pain	☐	☐
9. Other: _____		

• Hematological problems	Yes	Denies
1. Bleeding	☐	☐
2. Anemia	☐	☐
3. Sickle Cell	☐	☐
4. Blood transfusion	☐	☐
5. Other: _____		

• Renal (Urinary)	Yes	Denies
1. Incontinence / frequent urgency	☐	☐
2. Prostate disorder	☐	☐
3. Kidney disorder	☐	☐
4. Pain / burning on urination	☐	☐
5. UTI (Urinary Tract Infection)	☐	☐
6. Other: _____		

• Metabolic / Hepatic Problems	Yes	Denies
1. Diabetes	☐	☐
2. Liver disease/Jaundice/Hepatitis (A, B, C)	☐	☐
3. Thyroid disorder	☐	☐
4. Other: _____		

• Musculoskeletal	Yes	Denies
1. Falls	☐	☐
2. Fracture	☐	☐
3. Discoloration	☐	☐
4. Arthritis	☐	☐
5. Scoliosis	☐	☐
6. Back pain	☐	☐
7. Chronic pain	☐	☐
8. Other: _____		

• Sexual history	Yes	Denies
1. Have you:		
- Been sexually active?	☐	☐
- Practiced safe sex (used condom)	☐	☐
- Used birth control?	☐	☐
2. Have a sexually trans. disease	☐	☐
3. If yes, type: _____		
4. Other: _____		

• Male Reproductive Systems	Yes	Denies
1. Sores / Rash	☐	☐
2. Pain	☐	☐
3. Discharge	☐	☐
4. Other: _____		

• Female reproductive systems	Yes	Denies
1. Pain / Sores / Rash	☐	☐
2. Discharge	☐	☐

3. Age at onset of menses: _____
4. Last menses: _____
5. Missed Yes ☐ Denies ☐
   Date if missed: _____
6. Number of Pregnancies: _____
7. Number of Deliveries: _____
8. Other: _____

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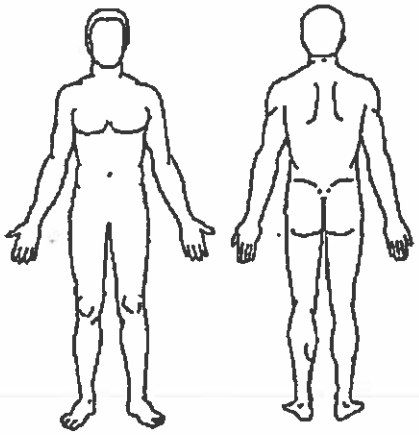
NURSING ADMISSION AND ASSESSMENT SUMMARY

PATIENT ID LABEL

MEDICAL HISTORY AND ASSESSMENT (CONTINUED)

• Skin (integument)	Yes	Denies
1. Rashes / Bruises / Scars	☐	☐
2. Tattoos / piercings	☐	☐
3. Moles / Other skin lesions	☐	☐
4. Lice / Scabies	☐	☐
5. Skin disorder	☐	☐
6. Other: _____		

Indicate location of skin condition below:



• Respiratory problems	Yes	Denies
1. Cough	☐	☐
a. Productive (of sputum)	☐	☐
b. Non-productive (dry cough)	☐	☐
2. Shortness of breath (SOB)	☐	☐
3. Bronchitis	☐	☐
4. Asthma	☐	☐
5. Emphysema	☐	☐
6. Other: _____		

• Posture – gait – motor activity	Yes	Denies
1. Stiff / rigid	☐	☐
2. Posturing	☐	☐
3. Slow	☐	☐
4. Tremors	☐	☐
5. Shuffling	☐	☐
6. Other: _____		

• Assistive devices	Yes	No
1. Braces / Prosthesis	☐	☐
2. Glasses / Contacts	☐	☐
3. Hearing aid	☐	☐
4. Dentures / Braces	☐	☐
5. Other: _____		

PSYCHIATRIC ASSESSMENT

• **Appearance, affect, emotional tone**

Symptom / behavior

1. Neat ☐	Unkempt ☐			
2. Cooperative ☐	Uncooperative ☐			
3. Engaged ☐	Withdrawn ☐			
4. Calm ☐	Anxious/Tense ☐	Agitated ☐		
5. Speech WNL ☐	Mute ☐	Loud ☐	Pressured ☐	
6. Euthymic ☐	Sad ☐	Manic ☐	Angry ☐	
7. Other: _____				

• Mental process	Good	Compromised
1. Understanding	☐	☐
2. Judgment	☐	☐
3. Memory	☐	☐

• Oriented to	Yes	No
1. Time	☐	☐
2. Place	☐	☐
3. Person	☐	☐

• **Alcohol – drug use (check all that apply)**

☐ Alcohol ☐ Stimulants ☐ Hallucinogen ☐ Meth
☐ Cocaine ☐ Inhalants ☐ Marijuana ☐ Caffeine
☐ Barbiturates ☐ Crack ☐ Drug of choice: _____
☐ **Tobacco:** No ☐ Yes ☐

If yes, ask if patient would like smoking cessation information; if so then provide patient with educational materials.

AUDIT C – ALCOHOL SCREEN *(adults ONLY)*

1. How often do you have a drink containing alcohol?

a. ☐ Never
b. ☐ Monthly or less
c. ☐ 2-4 times a month
d. ☐ 2-3 times a week
e. ☐ 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

a. ☐ 1 or 2
b. ☐ 3 or 4
c. ☐ 5 or 6
d. ☐ 7 to 9
e. ☐ 10 or more

3. How often do you have six or more drinks on one occasion?

a. ☐ Never
b. ☐ Less than monthly
c. ☐ Monthly
d. ☐ Weekly
e. ☐ Daily or almost daily

Allotted points: a=0 pts.; b=1 pt.; c=2 pts.; d=3 pts.; e=4 pts
TOTAL POINTS:_____*scored on a scale of 0-12*

If score of 4 or more for MALE, or 3 or more for FEMALE:
RN must complete "Alcohol Use Disorders Identification Test" Form NUR 20.30.10 F06 and forward to patient's Treatment Team:

☐ Form completed and forwarded to Treatment Team:
RN initials_____Date/Time_____

Medical History and Assessment (Pages 1–3) (Revised 04/27/2015); Psychiatric Assessment (Pages 3 and 4) (Revised 04/27/2015)

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NURSING ADMISSION AND ASSESSMENT SUMMARY

PATIENT ID LABEL

PSYCHIATRIC ASSESSMENT (CON'T)

• Suicide risk	Yes	Denies
1. Ideation	☐	☐
Current		
Past		
2. Past attempts at suicide	☐	☐
Describe:		
3. Family history	☐	☐
Describe:		
4. Self mutilates	☐	☐
5. Other:		

• Mental status / Thought process	Yes	No
1. Oriented	☐	☐
Disoriented	☐	☐
2. Thoughts clear	☐	☐
Paranoid	☐	☐
Hallucinations	☐	☐
Delusions	☐	☐

	Yes	Denies
3. No thoughts of harm	☐	☐
Thoughts of self-harm	☐	☐
Thoughts to harm others	☐	☐

4. Other: _____

OTHER ASSESSMENTS

• Educational Assessment	Yes	Denies
1. Compliance taking prescribed medications	☐	☐
2. Safe and effective use of medical equipment	☐	☐
3. Motivation to learn	☐	☐
4. Cognitive limitations	☐	☐
5. Special healthcare needs	☐	☐
6. Are you attending school?	☐	☐
8. Name of last school attended:		

• Cultural and Assessment	Yes	Denies
1. Do you have any cultural beliefs?	☐	☐
If yes, explain:		
- Any foods you may not eat?		
- Practices we need to know?		
2. Do you have any spiritual beliefs?	☐	☐
If yes, what is your spiritual higher power?		

3. Would you like to talk to a:
☐ pastor ☐ priest ☐ rabbi
☐ other _____

4. What language is commonly spoken in your home?

5. What language do you understand best?

Staff name & title (print) | Signature | Date | Time

Psychiatric Assessment (Pages 3 and 4) – (Revised 04/27/2015)

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MEDICATION RECONCILIATION
ADMISSION TO THE HOSPITAL OR IN-HOSPITAL TRANSFER

PATIENT ID LABEL

Complete this form upon patient admission to the hospital or for in-hospital transfers to another unit or program in the hospital. (Do not use the Discharge from the Hospital form for in-hospital transfers.)

Patient admitted from: ☐ Home ☐ Other ASH unit _____ ☐ Other

ALLERGY / DRUG REACTION – SHOW ALLERGY TO MEDICATION OR DRUG REACTION TO MEDICATION

☐ **No known allergies** ☐ **Allergies and drug reactions (list the medication and check the reaction)**

Medication	Allergy	Drug Reaction	Nausea/ Vomiting	Rash	Hives	Difficulty Breathing	Other
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	

Current medications the patient is taking

Include blood thinning products, over-the-counter-medication, herbal supplements currently being taken.

Sources of info: ☐ Patient ☐ Medication bottles ☐ Patient's family ☐ Med list ☐ Dr's office ☐ Old chart ☐ Pharmacy name: _____ Pharmacy #: _____ ☐ Other _____

CURRENT MEDICATIONS LIST:

List patient's current medications & check either Continue or D/C (Discontinue); the physician will write a rationale for each D/C'd medication under "Indications for Discontinuing Medication" (use MAR for XFers).

Continue	D/C	MEDICATION	DOSE (mg, ml etc.)	FREQUENCY	Route/ topical site	DATE & TIME of LAST DOSE	INDICATION FOR DISCONTINUING MEDICATION
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						
☐	☐						

ADDITIONAL MEDICATIONS ORDERED BY ADMITTING PHYSICIAN:

List additional medications ordered by admitting physician; the physician will write a rationale for each additional med in the column titled "Indications for New Medications" (should be none for XFers – use MAR).

START DATE	MEDICATION	DOSE (mg, ml etc.)	FREQUENCY	ROUTE OR TOPICAL SITE	INDICATION TO START NEW MEDICATION

Admitting nurse (print)	Admitting nurse signature	Date	Time
Admitting physician (print)	Admitting physician signature	Date	Time

[Use additional sheet if necessary] [New Admits: File this form at the beginning of admissions orders section; Transfers: File at end of Dr.'s orders & send a copy to new unit/program] ASH Form # ASH 11.08.04 F1, Medication Reconciliation--Admission to Hospital or In-Hospital Transfer

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NURSING ADMISSION AND ASSESSMENT SUMMARY

ADMISSION VIOLENCE RISK ASSESSMENT

PATIENT ID LABEL

Instructions: The RN who admits the patient completes this form.

☐ Unable to get history / assess at time of admission -- Explain in Comments below.

1.	Did patient display violence during previous ASH admissions?	☐ Unknown	☐ Yes	☐ No
2.	Has patient displayed violence in the community? (Includes but not limited to criminal behaviors and assaults at previous placements.)	☐ Unknown	☐ Yes	☐ No
3.	Did patient display extreme agitation or aggression at the time of admission?		☐ Yes	☐ No
4.	Did patient verbalize intent to harm others at the time of admission?		☐ Yes	☐ No
5.	Does patient admit to abusing drugs or alcohol in the last 12 months?		☐ Yes	☐ No

# of Yes answers: _____

If there are any Yes answers:

☐ ≥ 1 Yes -- Indicates patient is at increased risk of violence.

☐ ≥ 2 Yes – Report this score to Charge Nurse and Physician:

☐ Charge Nurse Nurse's name: _____

☐ Not reported – Charge Nurse not available

☐ Resident or Attending Physician Doctor's name: _____

☐ Not reported – Neither physician available.

Comments:

RN completing this form(print)	Signature	Date	Time

Admission Violence Risk Assessment (Page 6) (Revised 4/27/2015)

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NURSING ADMISSION AND ASSESSMENT SUMMARY

ANGER CONTROL SCREEN

PATIENT ID LABEL

INSTRUCTIONS: Complete upon admission with patient / family / guardian

What works best for you when you are upset? Check the things that help when you are having a hard time.

THINGS THAT HELP DURING HARD TIMES

- ☐ Voluntary time out away from peers
- ☐ Voluntary time out
- ☐ Sitting by a staff member
- ☐ Talking with another friend
- ☐ Talking to staff
- ☐ Punching a pillow or punching bag
- ☐ Writing in a diary / journal
- ☐ Deep breathing exercises
- ☐ Listening to music
- ☐ Pacing
- ☐ Exercise
- ☐ Reading a book
- ☐ Singing out loud
- ☐ Bouncing a ball
- ☐ Sitting in a rocking chair
- ☐ Other: _____
- ☐ Other: _____

STAFF USE ONLY

RISK FACTORS

Mark Yes or No below for each risk factor. For each "Yes" staff will initiate a plan of care and interventions to be considered by the Treatment Team.

Yes	No	Risk Factor
☐	☐	Paranoid thinking
☐	☐	Auditory commands / hallucinations
☐	☐	History of aggression in other facilities
☐	☐	History of threat to harm others
☐	☐	History of drug / alcohol abuse
☐	☐	Repeated admissions / placements
☐	☐	History of sexual abuse
☐	☐	History of physical abuse

TRIGGERS

What makes you mad or bothers you? Check all that apply.

- ☐ Being ignored
- ☐ Being touched
- ☐ Being isolated
- ☐ Loud noise
- ☐ Yelling
- ☐ Particular time of the day (When?) _____
- ☐ Particular time of the year (When?) _____
- ☐ Other: _____

Patient's name (print)	RN's name (print)	Date	Time
Patient's signature	RN's signature	Date	Time

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NURSING ADMISSION AND ASSESSMENT SUMMARY

ADMISSIONS FALL RISK ASSESSMENT

PATIENT ID LABEL

				Points
I. Age	☐ Age 1 – 64: **0** points	☐ Age 65 – 79: **1** point	☐ Age 80 plus: **2** points	
II. Mental status:	☐ Oriented, all times: **0** points	☐ Intermittent confusion: **3** points	☐ Confused at all times: **4** points	
III. Elimination:	☐ Independent / continent: **0** points	☐ Elimination with assistance: **1** point	☐ Dependent / incontinent: **2** points	
IV. Vision:	☐ Functional vision: **0** points	☐ Visual impairment: **1** point		

V. Gait and balance: assess patient's gait while patient:

1. Stands still for 30 seconds, both feet on the ground, not holding onto anything;
2. Walks straight forward;
3. Walks through a doorway;
4. Walks while making a turn.

[Check applicable boxes below]

☐ Wide base of support	= 1 point	☐ Lurching, swaying or slapping gait	= 1 point	
☐ Loss of balance while standing	= 1 point	☐ Gait pattern changed, through doorway	= 1 point	
☐ Balance problems while walking	= 1 point	☐ Jerking or instability when making turns	= 1 point	
☐ Decrease in muscular coordination	= 1 point	☐ Uses assistive device (cane, walker, etc.)	= 1 point	

VI. Medications: indicate if patient is currently taking or took listed medications before admission

☐ Antihistamine	☐ Cathartic	☐ Sedative / Hypnotic
☐ Anti-hypertensive	☐ Diuretic	☐ Other _____
☐ Anti-seizure / Anti-epileptic	☐ Hypoglycemic	☐ Other _____
☐ Benzodiazepine	☐ Psychotropic	☐ Other _____

Scoring:

☐ 0 medications	=	**0** points
☐ 1 medication	=	**1** point
☐ 2 or more medications	=	**2** points
☐ Change med/dose, last 5 days	=	**1** point

If the **TOTAL SCORE** is: **TOTAL SCORE** _____

0 – 9 points: No fall precautions indicated
10 or more points: Fall precautions indicated – request order for fall precautions

A Physician order is required to place a patient on or take a patient off Fall Precaution.

Assessed by (print)	Signature	Date	Time

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NURSING ADMISSION AND ASSESSMENT SUMMARY

CHOKING RISK ASSESSMENT

PATIENT ID LABEL

Reasons for assessment
1. Admission
2. Choking episode
3. Follow-up
4. Annual assessment
5. Other

	Wt.	Date: / Reason:	Date: / Reason:	Date: / Reason:	Date: / Reason:
MENTAL DISORDERS:		**SCORE**	**SCORE**	**SCORE**	**SCORE**
Neurocognitive Disorder	2				
Delirium	2				
PICA	2				
MEDICAL DIAGNOSES:					
Obesity	2				
Gastric reflux, history of	1				
Episodes of aspiration/aspiration pneumonia	4				
Obstructive sleep apnea	2				
Cerebral Vascular Accident (CVA)	2				
Degenerative neurological disease	2				
Parkinson's/Huntington's diseases/Cereb Pals	3				
Other movement disorders	1				
Other client-specific condition	1				
Tardive dyskinesia	4				
MEDICATIONS:					
Any medication causing sedation	1				
PHYSICAL CONDITIONS:					
Chewing, difficulty in	2				
Dentures	2				
Multiple teeth missing / absent / dental carries	2				
Swallowing difficulty: gagging/choking/cough	4				
Gag/choke on food and/or liquids	4				
EATING HABITS:					
Feeds self independently	0				
Needs assistance to eat	1				
Feeds self too fast (packs mouth with food)	2				
Totally dependent for eating	2				
Eating disorder	4				
SEATING POSITION:					
Sits at the table in regular chair	0				
Sits away from table in a wheelchair	1				
Sits away from table in a geri-chair	1				
Sits away from table in a regular chair	0				
TOTAL SCORE					

Risk score: 0 – 3 = **Minimal :** No dietitian consult required
Risk score: 4 – 8 = **Moderate:** Dietitian consult required; direct observation while eating
Risk score: 9 + = **Severe :** Dietitian consult required; **Report to the Physician**

Nurse signature: _____ Date: _____ Time: _____ Consult Y☐ N☐ Dr Informed Y☐ N☐
Nurse signature: _____ Date: _____ Time: _____ Consult Y☐ N☐ Dr Informed Y☐ N☐
Nurse signature: _____ Date: _____ Time: _____ Consult Y☐ N☐ Dr Informed Y☐ N☐
Nurse signature: _____ Date: _____ Time: _____ Consult Y☐ N☐ Dr Informed Y☐ N☐

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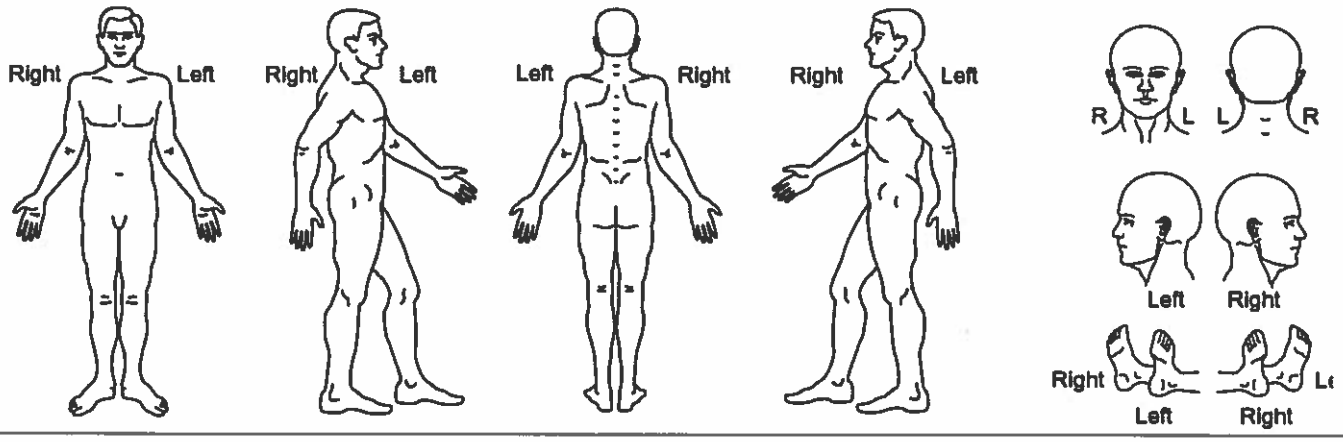
NURSING ADMISSION AND ASSESSMENT SUMMARY
PAIN ASSESSMENT

PATIENT ID LABEL

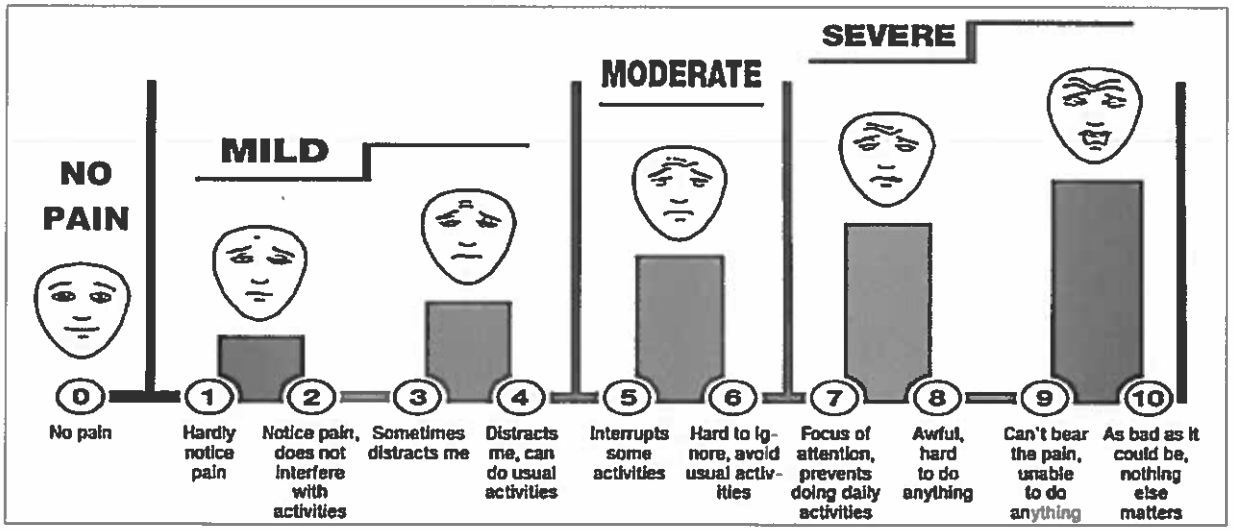
1. ***Do you have pain?*** ☐ Yes ☐ No If you have pain, what caused / triggers the pain?

2. ***Pain assessment:*** Examples of pain quality: sharp; dull; burning; throbbing; pricking; pins and needles; stabbing; aching; radiating:

3. ***Location of pain.*** Note region and radiation. (Patient may mark directly on drawing.)



4. ***Pain severity (see scale below)*** ***Right now:***_____ ***At its worst:***_____



At its best: _____ ***Highest acceptable level:*** _____

Related symptoms:

5. ***Time factors:***
   - Does the pain vary throughout the day? ☐ Yes ☐ No
   - When does the pain start? _____
   - How long does pain last?

6. ***Pain-related behaviors:***

7. ***Effects on functional status and quality of life:***

8. ***What decreases your pain?***

9. ***If pain is rated ≥ 3:***
   ☐ Yes ☐ No Initiated Nursing Care Plan "Acute and / or Chronic Pain (above 3 on pain scale)"
   ☐ Yes ☐ No Physician notified: Date: Time:

10. ***Treatment plan:*** _____

Name, Title (print)	*Signature*	*Date*	*Time*

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL

Instructions for Completing the ASH Trauma Assessment Screening Form

The following form Trauma Assessment Inpatient Screening Form (ASH 11.01.5 F 01), will be administered to the patient at the time of admission. However; if the patient doesn't want to complete the form at admission, the form may be completed at a later time (see ASH 11.01.05 A 01 FORM Instructions for Completing the Trauma Assessment Form and FORM ASH 11.01.05 F 01 FORM Trauma Assessment Screen for Inpatients) found in the ASH Policy Manual.

The trauma screen form is designed to be completed by the patient. However; if the patient is unable to read, the nurse will have to read the items to the patient and complete the form for the patient. If you are unsure whether or not the patient is able to read, ask him/her to read aloud the Instructional Note near the top. If the patient is able to read this section and then explain what it means, he/she should be able to complete the form independently.

Tell the patient:

> *"We would like you to complete this Trauma Screening Form. It asks you about several kinds of very bad experiences you may have had before. It will help your doctor and treatment team to understand how experiences such as that may have affected you.* ***This form is voluntary.*** *You do not have to fill it out if you don't want to. If you identify specific people who have abused you in the past, we will probably be required by law to report it to state authorities. This does not mean that the person(s) you report will automatically get into trouble. It does mean that a state agency will look into it, at how long ago it happened and whether you or someone else is still being hurt at the present. They will then make a decision whether to investigate it further or do anything else about it."*

Ask the patient if he/she have any questions about this, and try to answer those questions.
The underlying theme is that it helps us do a better job with treatment if we understand a patient's trauma history, and that the state law is very specific in requiring us to report possible episodes of abuse. If the patient doesn't want to fill out the form, accept his/her decision and simply note that in the chart.
If a patient is very psychotic, intoxicated or in some other way unable to fill out the form, simply note that in the chart. Administration should be attempted again in the next day or two, or after there has been some improvement.

When the form is completed, have it placed in the Assessments section of the chart.
If a patient identifies specific persons who abused him / her, you should report this to one of the following telephone numbers. If you are unsure about whether it needs to be reported, you may consult with the NOD. In general, the state agencies suggest that if you are unsure whether to report, it is better to go ahead and report it.

The state agencies to which you report possible abuse are:

Under 21 years of age:	Child Abuse Hotline:	1-800-482-5964
Over 21 years of age:	Adult Protective Services:	1-800-482-8049

Instructions for Treatment Teams on Responding to Trauma Assessments
When a Trauma Assessment identifies a specific person who abused a person many years ago, this should be discussed by the Treatment Team in regard to the question of whether or not to report it. If there is any reason to believe that the abuser may still be abusing people, it should be reported. In general, state agencies and our attorneys say it is better to err on the side of reporting than not reporting.

The state agencies to which you report possible abuse are:

Under 21 years of age:	Child Abuse Hotline:	1-800-482-5964
Over 21 years of age:	Adult Protective Services:	1-800-482-8049

DEPARTMENT OF HUMAN SERVICES DIVISION OF BEHAVIORAL HEALTH SERVICES ARKANSAS STATE HOSPITAL NURSING ADMISSION AND ASSESSMENT SUMMARY TRAUMA ASSESSMENT SCREEN - ADMISSION	PATIENT ID LABEL

THIS FORM IS VOLUNTARY

Note: We ask for this information to help us to understand how life experiences have affected you. You do not have to answer any questions that you don't want to. If you identify specific people who have abused you, we may be required by law in some circumstances to notify state authorities.

1. **Have you ever been physically abused?**
   Yes _____ No _____ Not sure _____
   If Yes: In childhood? _____ As a teenager? _____ As an adult? _____ Recently? _____
   Are you willing to share who did this to you? _____
2. **Have you ever been sexually abused or raped *(had unwanted sexual contact forced on you)*?**
   Yes _____ No _____ Not sure _____
   If Yes: In childhood? _____ As a teenager? _____ As an adult? _____ Recently? _____
   Are you willing to share who did this to you? _____
3. **Have you ever been a victim of a violent crime *(other than rape or sexual abuse)*?**
   Yes _____ No _____ Not sure _____ *If Yes*, please describe what happened to you and when it happened:
   _____
   _____
   _____
4. **Have you ever been in a severe accident or natural disaster?**
   Yes _____ No _____ Not sure _____ *If Yes*, please describe what happened to you and when it happened:
   _____
   _____
5. **If you answered Yes to any of the questions above, do you ever have:**
   Flashbacks? _____ Nightmares about what happened? _____
   Severe anxiety? _____ Staying away from other people? _____
6. **What kinds of experiences lead to the symptoms described above?**
   _____
   _____
7. **What can we do to help you feel calmer when you have such symptoms?**
   _____
   _____
8. **If in DHS custody:**
   - How old were you when you were placed in foster care? _____
   - How did you feel about being in DHS custody? _____
   - Are you in contact with your family? ☐ Yes ☐ No
   - When was the last time you saw or spoke with your family? _____

For Adolescents: ***Any and all abuse must be reported by the assessor within 24-hours:***
If yes: Call the Child Abuse Hotline: 1-(800)-482-5964

For Adults: ***Does the patient want the abuse reported?*** ☐ Yes ☐ No;
If yes: Call the Adult Abuse Hotline: 1-(800)-482-8049

Reviewed By:	Date:

See ASH Policy # ASH 11.01.05 (Trauma Assessment Screen) (Form Revised 01/06/2016)

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
NURSING DEPARTMENT

NURSING ADMISSION AND ASSESSMENT SUMMARY

TUBERCULOSIS RISK ASSESSMENT AND PPD FORM

PATIENT ID LABEL

1. **Where was the patient born?**
   - ☐ USA
   - ☐ Mexico/South or Central America
   - ☐ Asia
   - ☐ Southeast Asia
   - ☐ Africa
   - ☐ Eastern Europe
   - ☐ Western Europe

2. **If not born in USA, when did patient arrive in the United States?**
   - ☐ Within the past 2 years
   - ☐ 2 to 5 years ago
   - ☐ More than 5 years ago

3. **Has the patient ever had a skin test for Tuberculosis or had the BCG vaccine?**
   ☐ Yes ☐ No ☐ Not sure
   If Yes: Where? _____
   When? ____/____/____
   Result: ☐ Positive ☐ Negative

4. **Has the patient ever had a chest x-ray?**
   ☐ Yes ☐ No ☐ Not sure
   If Yes: Where? _____
   When? ____/____/____

5. **Tuberculosis usually causes one or more of these symptoms. Has the patient had any of the following in the past 3 weeks?**
   - ☐ Cough for longer than three weeks
   - ☐ Night sweats ☐ Fevers ☐ Fatigue
   - ☐ Loss of appetite ☐ Loss of weight
   - ☐ Other ☐ None

   If patient presents with two or more symptoms, please refer to primary physician or resident immediately.

6. **Please check all that apply. Has the patient:**
   - ☐ Ever been homeless, lived or worked in a shelter?
   - ☐ Ever lived or worked in a nursing home?
   - ☐ Ever been an inmate or worked in a jail or prison?
   - ☐ Ever been a healthcare worker?
   - ☐ Been vaccinated recently?
     If so, for what? _____
   - ☐ Ever drunk alcoholic drinks? How many a week?
     ☐ None ☐ 1 – 4 ☐ 5 – 6 ☐ ≥ 7
   - ☐ Ever used IV drugs or any other drugs?
     What kind? _____
   - ☐ Ever had TB or been treated for active or latent TB?
   - ☐ None of the above

7. **Has the patient had contact with or lived with persons:**
   - ☐ Who were sick with Tuberculosis?
   - ☐ Who were born or frequently traveled outside of the United States?
     Where? _____
   - ☐ Who used drugs or drink alcohol
   - ☐ None of the above

8. **Does the patient have or has the patient ever had any of these conditions or treatments?**
   - ☐ Diabetes
   - ☐ Immune system disorder
   - ☐ Steroid treatment for more than 2 weeks
   - ☐ Chemotherapy for cancer
   - ☐ Silicosis or lung disease from mining
   - ☐ Kidney failure that requires dialysis
   - ☐ Organ transplant or blood transfusions
   - ☐ Weight loss without trying, poor appetite, or poor nutrition, weight >10% below ideal weight
   - ☐ Positive test for HIV infection or AIDS
   - ☐ None of the above

TB testing recommended

- ☐ NO – Documented negative PPD within last 12 months
- ☐ NO – Documented prior positive PPD or prior TB diagnosis
- ☐ YES

+Type of Test	Date	Placed
PPD		Site / Signature

Based on information and above history

The PPD is: ☐ Negative ☐ Positive

Has a TB 109 been completed? ☐ Yes ☐ No
[Orig. to Clinic; consult to Infection Control Coordinator]

Chest x-ray (CXR) recommended?
☐ Yes ☐ No
(If active TB is suspected do a CXR – do not wait for PPD result, which may be a false negative)

Chest X-Ray:

Location: _____
Appointment date: _____
Date CXR done: _____
CXR reviewed by: _____

RN name (print)	RN signature	Date	Time

Tuberculosis Risk Assessment and PPD Form (Page 13) (Revised 5/10/2013)

Nursing

DEPARTMENT OF HUMAN SERVICES DIVISION OF BEHAVIORAL HEALTH SERVICES ARKANSAS STATE HOSPITAL DEPARTMENT OF NURSING NURSING ADMISSION AND ASSESSMENT SUMMARY NARRATIVE	PATIENT ID LABEL

Narrative:

Staff name & title (print) | Signature | Date | Time

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

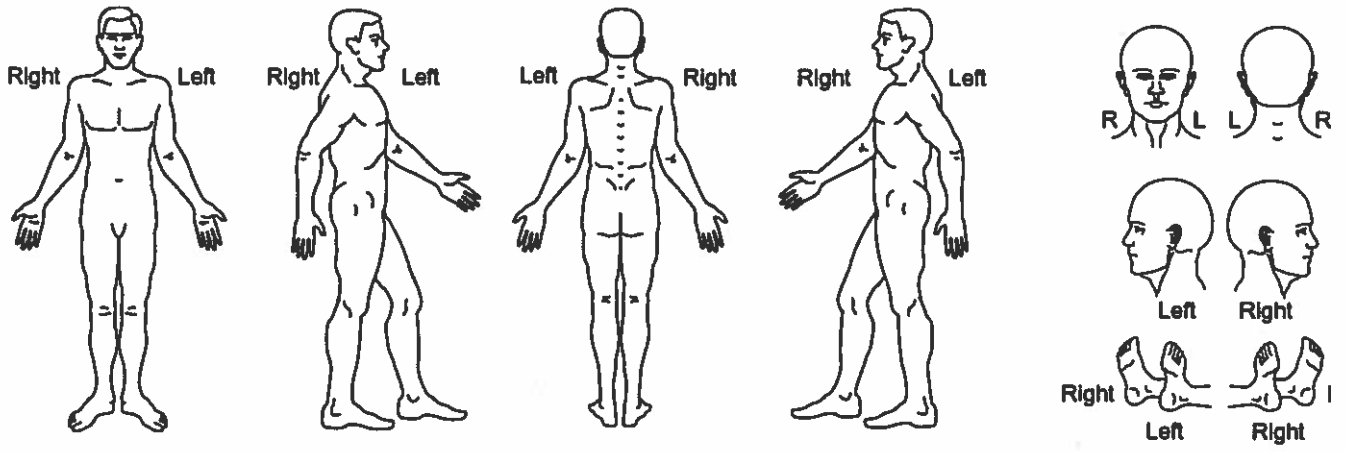
(STAND-ALONE) PAIN ASSESSMENT FORM

PATIENT ID LABEL

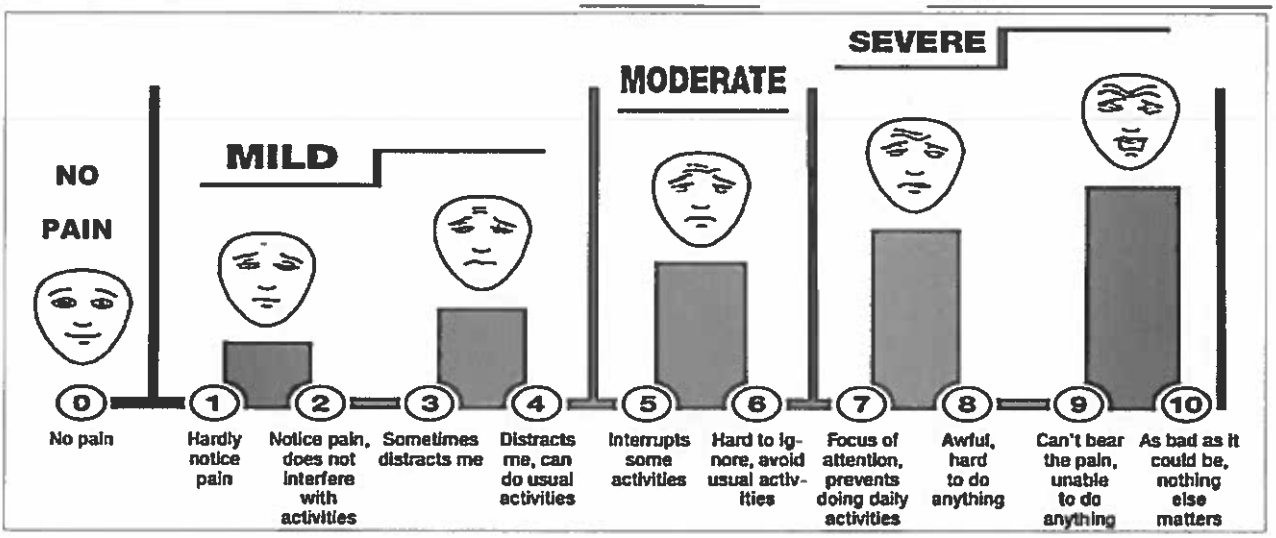
1. ***Do you have pain?*** ☐ Yes ☐ No
   If you have pain, what caused / triggers the pain?

2. ***Pain assessment:*** Examples of pain quality: sharp; dull; burning; throbbing; pricking; pins and needles; stabbing; aching; radiating.

3. ***Location of pain.*** Note region and radiation. (Patient may mark directly on drawing.)



4. ***Pain severity (see scale below)*** ***Right now:*** _____ ***At its worst:*** _____



At its best: _____ ***Highest acceptable level:*** _____

Related symptoms:

5. ***Time factors:***
   - Does the pain vary throughout the day? ☐ Yes ☐ No
   - When does the pain start? _____
   - How long does pain last?

6. ***Pain-related behaviors:***

7. ***Effects on functional status and quality of life:***

8. ***What decreases your pain?***

9. ***If pain is rated ≥ 3:***
   ☐ Yes ☐ No Initiated Nursing Care Plan "Acute and / or Chronic Pain (above 3 on pain scale)"
   ☐ Yes ☐ No Physician notified: Date: Time:

10. ***Treatment plan:*** _____

Name, Title (print)	*Signature*	*Date*	*Time*

Nursing

Department of Human Services
Division of Behavioral Health Services

ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

NURSING ASSESSMENT 12-MONTH CONTINUOUS SERVICE UPDATE, OR READMISSION WITHIN 30-DAYS *(ADULT and ADOLESCENT)*

PATIENT ID LABEL

This form is completed when a patient has had 12-months of continuous service at ASH, or is discharged from the hospital and returns WITHIN 30-days. If return is AFTER 30-days a complete new admission packet must be completed using NUR 20.30.10 F 01 Nursing Admission Assessment.

Check one: ☐ **Update**: Patient has had 12-mths continuous care
☐ **Readmission** (From facility name): _____

Level of Care: to _____ from _____ Date of change of level of care: _____

PATIENT PRESENTING PROBLEMS UPDATE

Presenting problem(s) from what patient indicates:

_____
_____
_____
_____

Presenting problems from what family / guardian indicates:

_____
_____
_____
_____

PATIENT PHYSICAL STATUS UPDATE

Review of changes in patient status: Body marks: ☐ Unchanged ☐ Changed as follows *(bruises, ulcerations, etc.)*

_____
_____
_____

Weight: _____ Height: _____ BMI: _____ Waist measure: _____
Temp: _____ Pulse: _____ Resp: _____ Blood pressure: _____ / _____
Sleep patterns: ☐ Unchanged ☐ Changed as follows:
☐ WNL ☐ Increased ☐ Decreased ☐ Insomnia ☐ Early morning awakening ☐ Uses hypnotics
Average hours of sleep per night: _____ ☐ No complaints
☐ Other (i.e., nightmares) Describe:

_____
_____
_____

NUTRITIONAL UPDATE

☐ There are no concerns with appetite or weight. ☐ There are concerns or changes in appetite or weight as follows:

_____
_____
_____

☐ Meets criteria for nutrition consult.

EDUCATIONAL NEEDS *(Additional Patient / Family Educational Needs Identified)*

_____
_____
_____

ENVIRONMENTAL NEEDS UPDATED ☐ Needs unchanged ☐ Needs changed as follows:

_____
_____

Nursing

Department of Human Services
Division of Behavioral Health Services

ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

NURSING ASSESSMENT 12-MONTH CONTINUOUS SERVICE UPDATE, OR READMISSION WITHIN 30-DAYS *(ADULT and ADOLESCENT)*

PATIENT ID LABEL

EMOTIONAL / BEHAVIORAL STATUS UPDATE

Danger to self: ☐ No ☐ Yes as evidenced by: _____

Danger to others: ☐ No ☐ Yes as evidenced by: _____

Danger to property: ☐ No ☐ Yes as evidenced by: _____

Disorientation: ☐ No ☐ Yes as evidenced by: _____

Runaway: ☐ No ☐ Yes as evidenced by: _____

Behavior, patterns and responses: ☐ Unchanged ☐ Changed as follows:

_____

_____

_____

MENTAL STATUS UPDATE

General appearance: _____

Any changes in mental status (i.e., memory, psychomotor): ☐ No ☐ Yes *(if Yes, describe below)*

_____

_____

_____

Mood / affect:

☐ Aggressive ☐ Agitated ☐ Angry ☐ Anxious ☐ Defensive ☐ Depressed
☐ Detached ☐ Euphoric ☐ Euthymic ☐ Fearful ☐ Flat ☐ Irritable ☐ Labile
☐ Passive ☐ Resistive ☐ Tense ☐ Uncooperative ☐ Withdrawn

Orientation: **Person:** ☐ Yes ☐ No **Place:** ☐ Yes ☐ No **Time:** ☐ Yes ☐ No

Judgment: ☐ Appropriate *(for age)* ☐ Inappropriate

Insight to condition: ☐ Present ☐ Absent

ABUSE UPDATE *(Re-Admit only)*

The patient admits to abuse since change in level of care: ☐ Yes ☐ No ☐ N/A – annual update

If yes, the patient / significant other / guardian has changed the account of history as follows:

_____

_____

Required for Adolescents:

Any and all abuse must be reported by assessor within 24-hrs to DHS Abuse Hot Line (1-800-482-5964)

Adults:

Does the adult patient want the abuse reported? ☐ No ☐ Yes *(if yes call 1-800-482-8049)*

SUBSTANCE ABUSE UPDATE *(Recent use of substances)*

Substance	*Route (specify if needles shared)*	*Dosage*	*Times used*	*Last used*

Describe any accompanying symptoms (i.e. blackouts, etc.)

_____

_____ _____ _____

PRINT - Nurse name and title *Signature* *Date / Time*

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

ALCOHOL USE DISORDERS IDENTIFICATION TEST
(ADULTS ONLY)

PATIENT ID LABEL

This form is completed when indicated by the results of the **AUDIT C – ALCOHOL SCREEN** in the *"Medical History and Assessment"* section of the Nursing Admission/Assessment Summary # NUR 20.30.10 F 01. If there was a score of 4 or more for a MALE, or 3 or more for a FEMALE, the RN must complete this form and forward it to the patient's Treatment Team. A total score of 8 or more on this test indicates harmful drinking behavior.

☐ **CHECK HERE IF PATIENT REFUSED TEST – Sign the bottom of this form, COPY and forward to Treatment Team**

Question # 1: ***How often do you have a drink containing alcohol?***
(0 pt) ☐ Never (skip to Questions 9-10)
(1 pt) ☐ Monthly or less
(2 pt) ☐ 2 to 4 times a month
(3 pt) ☐ 2 to 3 times a month
(4 pt) ☐ 4 or more times a week

Question # 2: ***How many drinks containing alcohol do you have on a typical day when you are drinking?***
(0 pt) ☐ 1 or 2
(1 pt) ☐ 3 or 4
(2 pt) ☐ 5 or 6
(3 pt) ☐ 7, 8, or 9
(4 pt) ☐ 10 or more

Question # 3: ***How often do you have six (6) or more drinks on one (1) occasion?***
(0 pt) ☐ Never
(1 pt) ☐ Less than monthly
(2 pt) ☐ Monthly
(3 pt) ☐ Weekly
(4 pt) ☐ Daily or almost daily

Question # 4: ***How often during the last year have you found that you were not able to stop drinking once you had started?***
(0 pt) ☐ Never
(1 pt) ☐ Less than monthly
(2 pt) ☐ Monthly
(3 pt) ☐ Weekly
(4 pt) ☐ Daily or almost daily

Question # 5: ***How often during the last year have you failed to do what was normally expected from you because of drinking?***
(0 pt) ☐ Never
(1 pt) ☐ Less than monthly
(2 pt) ☐ Monthly
(3 pt) ☐ Weekly
(4 pt) ☐ Daily or almost daily

Question # 6: ***How often during the last year have you been unable to remember what happened the night before because you had been drinking?***
(0 pt) ☐ Never
(1 pt) ☐ Less than monthly
(2 pt) ☐ Monthly
(3 pt) ☐ Weekly
(4 pt) ☐ Daily or almost daily

Question # 7: ***How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?***
(0 pt) ☐ Never
(1 pt) ☐ Less than monthly
(2 pt) ☐ Monthly
(3 pt) ☐ Weekly
(4 pt) ☐ Daily or almost daily

Question # 8: ***How often during the last year have you had a feeling of guilt or remorse after drinking?***
(0 pt) ☐ Never
(1 pt) ☐ Less than monthly
(2 pt) ☐ Monthly
(3 pt) ☐ Weekly
(4 pt) ☐ Daily or almost daily

Question # 9: ***Have you or someone else, been injured as a result of your drinking?***
(0 pt) ☐ No
(2 pt) ☐ Yes, but not in the last year
(4 pt) ☐ Yes, during the last year

Question # 10: ***Has a relative, friend, doctor, or other health professional expressed concern about your drinking or suggested you cut down?***
(0 pt) ☐ No
(2 pt) ☐ Yes, but not in the last year
(4 pt) ☐ Yes, during the last year

SCORING: Add up the points associated with answers, sign below, COPY form, and forward to the patient's Treatment Team

TOTAL SCORE:_____

☐ Form was copied and forwarded to Treatment Team: RN initials_____

_____	_____	_____
PRINT - Nurse name and title	*Signature*	*Date / Time*

Nursing

AUDIT – C / Guidelines for Treatment Teams

AUDIT-C - Overview

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument.

Clinical Utility

The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders.

Scoring

The AUDIT-C is scored on a scale of 0-12.

Each AUDIT-C question has 5 answer choices. Points allotted are:
a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

- **In men**, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- **In women**, a score of 3 or more is considered positive (same as above).
- However, when the points are all from Question #1 alone (#2 & #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the past few months to confirm accuracy.[3]
- Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Psychometric Properties

For identifying patients with heavy/hazardous drinking and/or Active-DSM alcohol abuse or dependence

	Men[1]	Women[2]
≥3	Sens: 0.95 / Spec. 0.60	Sens: 0.66 / Spec. 0.94
≥4	Sens: 0.86 / Spec. 0.72	Sens: 0.48 / Spec. 0.99

For identifying patients with active alcohol abuse or dependence

≥ 3	Sens: 0.90 / Spec. 0.45	Sens: 0.80 / Spec. 0.87
≥ 4	Sens: 0.79 / Spec. 0.56	Sens: 0.67 / Spec. 0.94

1. *Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT Alcohol Consumption Questions (AUDIT-C): An effective brief screening test for problem drinking. Arch Internal Med. 1998 (3): 1789-1795.*
2. *Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female veterans affairs patient population. Arch Internal Med Vol 163, April 2003: 821-829.*
3. *Frequently Asked Questions guide to using the AUDIT-C can be found via the website: www.oqp.med.va.gov/general/uploads/FAQ%20AUDIT-C*

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
NURSING SERVICES

(STAND-ALONE) ANGER CONTROL SCREEN

PATIENT ID LABEL

INSTRUCTIONS: To be completed with patient / family / guardian at any time necessary after admission. *(This form is also included in the admission packet and is completed at that time.)*

What works best for you when you are upset? Check the things that help when you are having a hard time.

THINGS THAT HELP DURING HARD TIMES

- ☐ Voluntary time out away from peers
- ☐ Voluntary time out
- ☐ Sitting by a staff member
- ☐ Talking with another friend
- ☐ Talking to staff
- ☐ Punching a pillow or punching bag
- ☐ Writing in a diary / journal
- ☐ Deep breathing exercises
- ☐ Listening to music
- ☐ Pacing
- ☐ Exercise
- ☐ Reading a book
- ☐ Singing out loud
- ☐ Bouncing a ball
- ☐ Sitting in a rocking chair
- ☐ Other: _____
- ☐ Other: _____

STAFF USE ONLY

RISK FACTORS

Mark Yes or No below for each risk factor. For each Yes staff will initiate a plan of care and interventions to be considered by the Treatment Team.

Yes	No	Risk Factor
☐	☐	Paranoid thinking
☐	☐	Auditory commands / hallucinations
☐	☐	History of aggression in other facilities
☐	☐	History of threat to harm others
☐	☐	History of drug / alcohol abuse
☐	☐	Repeated admissions / placements
☐	☐	History of sexual abuse
☐	☐	History of physical abuse

TRIGGERS

What makes you mad or bothers you? Check all that apply.

- ☐ Being ignored
- ☐ Being touched
- ☐ Being isolated
- ☐ Loud noise
- ☐ Yelling
- ☐ Particular time of the day (When?) _____
- ☐ Particular time of the year (When?) _____
- ☐ Other: _____

Patient's name (print)	RN's name (print)	Date	Time
Patient's signature	RN's signature	Date	Time

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

FALL RISK ASSESSMENT AND REASSESSMENT

PATIENT ID LABEL

		Date:	Date:	Date:	Date:
AGE:	**Wt.**	**SCORE**	**SCORE**	**SCORE**	**SCORE**
Age 1 – 64:	0				
Age 65 – 79:	1				
Age 80 plus:	2				
MENTAL STATUS:					
Oriented at all times:	0				
Intermittent confusion:	3				
Confused at all times:	4				
ELIMINATION:					
Independent / continent:	0				
Elimination with assistance:	1				
Dependent / incontinent:	2				
VISION:					
Functional vision:	0				
Visual impairment:	1				
GAIT / BALANCE – Assess while patient: (1.) Stands still for 30-seconds with both feet on ground, not holding onto anything (2.) Walks straight forward (3.) Walks through a doorway (4.) Walks while making a turn **Check Applicable Boxes Below:**					
☐ Wide base of support	1				
☐ Loss of balance while standing	1				
☐ Balance problems while walking	1				
☐ Decrease in muscular coordination	1				
☐ Lurching, swaying or slapping gait	1				
☐ Gait pattern changed through doorway	1				
☐ Jerking or instability when making turns	1				
☐ Uses assistive device (cane, walker, etc.)	1				

MEDICATIONS: Check to indicate if patient is currently taking or took listed medications in last five (5) days:

☐ Antihistamine ☐ Cathartic ☐ Sedative / Hypnotic
☐ Anti-hypertensive ☐ Diuretic ☐ Other_____
☐ Anti-seizure / Anti-epileptic ☐ Hypoglycemic ☐ Other_____
☐ Benzodiazepine ☐ Psychotropic ☐ Other_____

No (0) medications:	0				
One (1) medication:	1				
Two (2) or more medications:	2				
Change in med or dose in last five (5) days:	1				
TOTAL SCORE					

Risk score: 0 – 9 points = Minimal: ***No fall precaution indicated***
Risk score: 10 or more points = Moderate: ***Fall precaution indicated; request order for fall precautions***

A PHYSICIAN'S ORDER IS REQUIRED TO PLACE A PATIENT ON OR TAKE A PATIENT OFF FALL PRECAUTIONS

Nurse signature: _____ Date: _____ Time: _____ Consult Y☐ N☐ Dr Informed Y☐ N☐
Nurse signature: _____ Date: _____ Time: _____ Consult Y☐ N☐ Dr Informed Y☐ N☐
Nurse signature: _____ Date: _____ Time: _____ Consult Y☐ N☐ Dr Informed Y☐ N☐
Nurse signature: _____ Date: _____ Time: _____ Consult Y☐ N☐ Dr Informed Y☐ N☐

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

NEUROLOGICAL ASSESSMENT - SUSPECTED HEAD INJURY

PATIENT ID LABEL

Date started: ____ Time: ____ Military, ex. 0515
- 1st 8 hrs - assess every 2 hours
- 2nd 16 hrs - assess every 4 hours

		0 hrs	2 hrs	4 hrs	6 hrs	8 hrs	12 hrs	16 hrs	20 hrs	24 hrs
	Date (mm/dd):									
	Time (military)									
EYES OPEN	SPONTANEOUSLY									
	TO SPEECH									
	TO PAIN									
	NONE									
BEST VERBAL RESPONSE	ORIENTED									
	CONFUSED									
	INAPPROPRIATE									
	INCOMPREHENSIBLE									
	NONE / PATIENT VERBAL									
	NONE / NON-VERBAL									
BEST MOTOR RESPONSE	OBEYS COMMANDS									
	LOCALIZES PAIN									
	FLEXION TO PAIN									
	EXTENSION TO PAIN									
	NONE									
PUPILS	RIGHT SIZE (mm)									
	REACTION									
	LEFT SIZE (mm)									
	REACTION									

FIGURE 3-21 ◆ Variations in pupil diameters in millimeters.

ARMS	NORMAL POWER									
	MILD WEAKNESS									
	SEVERE WEAKNESS									
	SPASTIC FLEXION									
	EXTENSION									
	NO RESPONSE									
LEGS	NORMAL POWER									
	MILD WEAKNESS									
	SEVERE WEAKNESS									
	SPASTIC FLEXION									
	EXTENSION									
NORMAL STATUS	IS THIS A CHANGE FROM PATIENT'S NORMAL STATUS? YES									
	NO									
VITAL SIGNS	TEMPERATURE									
	BLOOD PRESSURE									
	PULSE									
	RESPIRATORY RATE									

Discuss any changes in status in the Progress Notes. If extremeties differ, note "R" for Right and "L" for left

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

NEUROLOGICAL ASSESSMENT - SUSPECTED HEAD INJURY

PATIENT ID LABEL

Date started: _____ Time: _____ Military, ex. 0515
- 1st 8 hrs - assess every 2 hours
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		0 hrs	2 hrs	4 hrs	6 hrs	8 hrs	12 hrs	16 hrs	20 hrs	24 hrs
	Date (mm/dd):									
	Time (military)									
EYES OPEN	SPONTANEOUSLY									
	TO SPEECH									
	TO PAIN									
	NONE									
BEST VERBAL RESPONSE	ORIENTED									
	CONFUSED									
	INAPPROPRIATE									
	INCOMPREHENSIBLE									
	NONE / PATIENT VERBAL									
	NONE / NON-VERBAL									
BEST MOTOR RESPONSE	OBEYS COMMANDS									
	LOCALIZES PAIN									
	FLEXION TO PAIN									
	EXTENSION TO PAIN									
	NONE									
PUPILS	RIGHT SIZE (mm)									
	REACTION									
	LEFT SIZE (mm)									
	REACTION									

FIGURE 3-21 ◆ Variations in pupil diameters in millimeters.

ARMS	NORMAL POWER									
	MILD WEAKNESS									
	SEVERE WEAKNESS									
	SPASTIC FLEXION									
	EXTENSION									
	NO RESPONSE									
LEGS	NORMAL POWER									
	MILD WEAKNESS									
	SEVERE WEAKNESS									
	SPASTIC FLEXION									
	EXTENSION									
NORMAL STATUS	IS THIS A CHANGE FROM PATIENT'S NORMAL STATUS? YES									
	NO									
VITAL SIGNS	TEMPERATURE									
	BLOOD PRESSURE									
	PULSE									
	RESPIRATORY RATE									

Discuss any changes in status in the Progress Notes. If extremeties differ, note "R" for Right and "L" for left

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL

SEIZURE OBSERVATION FORM

PATIENT ID LABEL

Pt. Name: _____ Date seizure observed: _____
Medical Record #: _____ Time seizure occurred: _____ ☐ AM ☐ PM
Unit: _____ Date: _____ Time: _____ Time seizure ended: _____ ☐ AM ☐ PM
Observing staff: _____ Location of seizure: _____

GENERAL DESCRIPTION

Did you see the beginning of the seizure? ☐ Yes ☐ No
Activity before seizure? _____
Did the individual give any warning signs? ☐ Yes ☐ No
If YES, please describe: _____

ACTIVITY DURING SEIZURE

Number the events below in order of occurrence; if events are simultaneous, assign the same number

GENERAL		STIFFNESS	JERKING	OTHER
☐ Lost consciousness	☐ Fell	☐ R – Arm	☐ R -- Arm	
☐ Change in color	☐ Stared	☐ L – Arm	☐ L – Arm	
☐ Bit tongue	☐ Incontinent B&B	☐ R – Leg	☐ R – Leg	
☐ Impaired speech	☐ Lip smacking	☐ L – Leg	☐ L – Leg	
☐ Drooling	☐ Eyes rolled back	☐ Body arch	☐ R – Face	
☐ Blinked eyes	☐ Vomited	☐ Eyes to right	☐ L – Face	
☐ Frothed at mouth	☐ Epileptic cry	☐ Eyes to left	☐ All	

ACTIVITY AFTER SEIZURE

Check all activities that occurred

☐ Confusion ☐ Slept ☐ Injury ☐ Body ache ☐ Other
☐ Nausea ☐ Weak ☐ Combative ☐ Vomited _____
☐ Headache ☐ Drowsy ☐ Agitated ☐ Resumed activity _____

[ADDITIONAL COMMENTS OR NARRATIVE – CONTINUE ON BACK]

SIGNATURE OF STAFF COMPLETING THIS REPORT

Staff name & title (print) _____ Signature _____ Date _____ Time _____

AREA BELOW TO BE COMPLETED BY A LICENSED NURSE

NURSING ASSESSMENT & INTERVENTIONS

Vital signs: T _____ P _____ R _____ B/P _____ / _____ O_2 Sat % _____ BS _____
PERRLA ☐ Yes ☐ No (explain on separate sheet)
Contributing factor(s): ☐None ☐Low BS ☐Infection ☐Impaction ☐Other (use other sheet) LOC _____
☐ DRE (if indicated) ____ ☐ Last BM ____ ☐ Guardian notified -- Name _____ Date/Time _____
☐ Attending Physician notified Name _____ Date _____ Time _____
☐ Hospital transfer initiated Date _____ Time _____
☐ Medication given to stop seizure ☐ Diazepam 10 mg IM; ☐ Other AEM given: _____ Route ☐PO ☐GT
☐ Lorazepam 2mg IM x1;
☐ DX test ordered ☐ Blood level ☐ EEG ☐ C/T ☐ MRI ☐ Neurologist notified ☐ Neuro consult ordered
OBSERVATION COMMENTS: Use second sheet to record any injury sustained during the event and/or any reports of

Nurse's name (print) _____ Signature _____ Date _____ Time _____

SEIZURE TYPE

☐ Absence seizure ☐ Atonic seizure ☐ Myoclonic seizure ☐ Partial seizure (simple) ☐ Partial seizure (complex)
☐ Tonic-clonic seizure ☐ Tonic seizure ☐ Clonic seizure ☐ Partial seizure, secondary generalization
☐ Other/Unknown _____ ☐ Cluster

Nursing

SEIZURE OBSERVATION FORM BACK PAGE (Page 2)

Patient's name: _____ Unit: _____ Date: _____ Time: _____

Arkansas State Hospital – Department of Nursing

Glucometer Training for Stat Strip Xpress Glucose Meter

1. **ORDERING SUPPLIES** – Supplies will be ordered from Material Management:
   - Batteries
   - Lancets
   - Strips (exp. 6 months after opening)
   - High/Low Solutions (exp. 90 days after opening)

2. **CHECKING THE BATTERY**
   A. Turn the meter on by pressing the "M" power button.
   B. Check battery bar for an estimate of remaining battery power.
   C. Order batteries from Material Management if needed.
   D. Replace battery if needed.

3. **CONTROL SOLUTION TEST**
   A. Insert a test strip into the meter. All segments of screen will display for 2 seconds. Then a flashing blood drop will display.
   B. Gently shake the control solution vial.
   C. Touch the end of the test strip at a 90 degree angle to a drop of control solution until the test strip fills and the meter beeps.
   D. Write the expiration date on Control (high/low) bottle after opening. Expires 90 days after opening.
   E. Write the expiration date on the test strip bottle after opening. Expires 6 months after opening.
   F. Document results onto NUR 60.30.10 F3 Bedside Glucometer Testing Quality Control Sheet.

4. **PATIENT BLOOD TEST**
   A. Turn the meter on.
   B. Insert a test strip into the meter. All segments of screen will display for 2 seconds. Then a flashing flood drop will display.
      Note: If strip is removed before the test starts or is not used for over 2 minutes, the screen will go blank.
   C. Wash patient's hand with water then dry thoroughly. Alternatively, use alcohol pads to clean area; dry thoroughly after cleaning.
   D. Holding hand downward, massage finger with thumb toward tip to stimulate blood flow.
   E. Use a lancet to puncture the finger.
   F. Squeeze the finger to form a drop of blood.
   G. When the blood drop appears, touch the end of the test strip at a 90 degree angle to the blood drop until the test strip fills and the meter beeps.
   H. Glucose test results are available on-screen in 6 seconds.
      Important: Do not remove the test strip until the countdown is complete.
   I. There is one long beep when the results are ready. There are 3 short beeps if test results are outside the range of the test strip. If result is LOW (less than the measurement range) or HIGH (greater than the measurement range) repeat the test.
   J. Remove the test strip and dispose of it properly.
   K. Record the result.

5. **CLEANING AND MAINTENANCE**
   A. The employee will wear gloves whenever he/she handles the Stat Strip Xpress glucometer.
   B. The meter will be cleaned between patient use by the RN or LPN/LPTN trained to operate the Stat Strip Xpress, and during the QC checks every 24 hours.
   C. The meter should be wiped down with a PDI Germicidal disposable wipe. Allow the meter to air dry for 60 seconds. Thoroughly dry with a soft cloth or lint-free tissue.
   Caution:
      - Do not get water or alcohol inside the meter.
      - Never immerse the meter or hold it under running water because it will damage the meter.
      - Do not spray the meter with a disinfectant solution.

Nursing

DEPARTMENT OF HUMAN SERVICES DIVISION OF BEHAVIORAL HEALTH SERVICES ARKANSAS STATE HOSPITAL DEPARTMENT OF NURSING MONTHLY INDIVIDUAL SEIZURE TRACKING REPORT	PATIENT ID LABEL

Patient's Name: _____ Unit: _____ Month: _____ Year: _____

Date	# Seizures/Shift 7A-7P	7P-7A	Total / Day (7A – 7A)	Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
Totals	_____	_____	_____	

CUMULATIVE SEIZURE DATA

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total

Nursing

ARKANSAS STATE HOSPITAL Department of Nursing **MEDICATIONS BROUGHT INTO THE HOSPITAL (BY PATIENT)**	Patient Label

ADULT PATIENTS:
If an adult patient brings medications into the hospital, the unit nurse will place the patient's name and information label on this form, and then record the medications below.

a) If a patient brings narcotics to the unit as a part of their medications, these will be counted by two nurses and placed on a narcotics count sheet and on this sheet.

b) The medications are then forwarded to the pharmacy with this form (and narcotics form if any).

c) If admission is after-hours and/or on a weekend, the medications are kept in a locked cabinet in the medication room on the unit after being recorded, until the next business day.

ADOLESCENT PATIENTS:
No medications are allowed to be left at the hospital if medications are brought with the adolescent.

This is not a medication history – only medications brought in by patient.

MEDICATION	STRENGTH	AMOUNT	COMMENT

NOT A PART OF PATIENT'S RECORD

Date Received BY PHARMACY: _____ Pharmacy Tech Initials: _____

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

IMMUNIZATION RECORD

PATIENT ID LABEL

Person receiving immunization: ☐ Patient ☐ Staff

Last Name: _____ First Name: _____ MI: ____ Race: _____

☐ Male ☐ Female Date of Birth: _____ Medicaid Number: _____

Home Address:

Street: _____ City: _____ State: _____ Zip Code _____

Home phone number: _____

History of Varicella (Chicken Pox)? ☐ Yes ☐ No _____

Vaccine Information:

Type of Vaccine: ☐ TD ☐ HEP-B ☐ 1 ☐ 2 ☐ 3 ☐ MMR ☐ FLU ☐ Other: _____

Dosage of Vaccine: _____

Route of Vaccine: _____

Site Given: ☐ R – Right Arm ☐ L – Left Arm

Date Given: _____

Manufacturer: _____

Mfr's Lot Number: _____

Person administering the vaccine:

Staff name & title (print)	Signature	Date	Time

Route Copy to Infection Control Nurse

Nursing

Arkansas Department of Human Services
Division of Behavioral Health Services
ARKANSAS STATE HOSPITAL

VISIT OUT / NURSING DISCHARGE STATEMENT

PATIENT ID LABEL

CHECK ONE: ***Is this a VISIT OUT or a DISCHARGE?*** DATE: _____ UNIT: _____

IF VISIT OUT ☐→ **TIME OUT:** _____ **RETURN DATE / TIME:** _____ *(Notify Admissions Dept. of return time)*

IF DISCHARGE STATEMENT ☐→ **TIME OUT:** _____ *(Get patient / guardian signature below)*

DESTINATION: _____

VISIT OUT or DISCHARGE To:

Jail / corrections ☐ DYS / DCFS ☐
Court ☐ _____
Family / Friends ☐ _____
Case Manager ☐ _____

TRANSPORT BY

Private Car ☐ Cab ☐ ASH ☐ MEMS ☐ Sheriff ☐
Other ☐ _____

ITEMS SENT WITH PATIENT

Medication ☐ No ☐ Yes _____
Aftercare plan ☐ No ☐ Yes _____
Personal property / effects ☐ No ☐ Yes _____

PHYSICAL CONDITION

Document in Progress Notes

Stable ☐ Yes ☐ No Other ☐
Ambulatory ☐ Yes ☐ No _____

MOOD

AFFECT Bright ☐ Flat ☐ Sad ☐ Angry ☐ Labile ☐ Normal ☐ Depressed ☐ Elated ☐ Anxious ☐ Angry ☐

ORIENTED X1 ☐ X2 ☐ X3 ☐ X4 ☐ X5 ☐

ALERT X1 ☐ X2 ☐ X3 ☐ X4 ☐ X5 ☐

COMMENTS _____

UAMS CLINIC REFERRALS

Dermatology ☐ Emergency Room ☐ PT ☐ Pulmonary ☐ Jones Eye Clinic ☐ ENT ☐
Cardiology ☐ Internal Medicine ☐ GI ☐ Neurology ☐ Infectious Disease ☐ PRI ☐
Neurology ☐ Rheumatology ☐ Urology ☐ OB / GYN ☐ Hematology / Oncology ☐ Orthopedics ☐
Nephrology ☐ Neurosurgery ☐ Surgery ☐ Trauma ☐ Radiology ☐ _____ *(MRI, CT, Echo and/or PET)*

Other UAMS Clinic or Acute medical facility _____

REFERRED TO (Other than UAMS)

CMHC ☐ *(Comm. Mental Health Ctr)* Private MD/Dentist ☐ Substance abuse facility ☐ Other MH / MR facility ☐ OTHER ☐

Arkansas Children's Hospital
ACH ☐ Emergency Room
ACH ☐ Clinic *(identify)*

Provide details for facility checked; i.e. WHICH Dentist or WHICH DYS facility or ACH Clinic.

_____

COMPLETE THIS SECTION BEFORE E-MAILING

PRINT: NAME OF AUTHORIZING DOCTOR: _____

PRINT: NAME OF NURSE RELEASING PATIENT: _____

PRINT: NAME OF ASH TRANSPORT STAFF *(If applies)*: _____

PLEASE NOTE ***If this is a "DISCHARGE STATEMENT" → → SEND DOCTOR'S ORDER TO ADMISSIONS***

For "VISIT OUT" check this box & provide intials to show a Doctor's Order has been written → → ☐ A Doctor's Order has been written; **Initials:** _____

1) FORM E-MAILED TO ***"DHS ASH Visit Out Report"*** By: _____ → → Date: _____ Time: _____
(PRINT or Type Name)

2) IF VISIT OUT - UPDATE RETURN TIME IN FIRST BOX ABOVE AND EMAIL FORM (Must include your name, date & time emailed below)
FORM E-MAILED TO ***"DHS ASH Visit Out Report"*** By: _____ → → Date: _____ Time: _____
(PRINT or Type Name)

For DISCHARGE STATEMENT ONLY

PHOTO IDENTIFICATION VERIFICATION IS REQUIRED FOR THE PERSON RECEIVING THE PATIENT

PATIENT IS BEING RELEASED TO: *Presented Picture ID?* ☐ Yes ☐ No

PRINT NAME of Guardian or Person Accepting the Patient *(If applicable)* _____

SIGNATURE of Guardian or Person Accepting the Patient _____

Street Address _____

PATIENT Signature *(If applicable)* _____

City _____ State Zip

SIGN AND COMPLETE BEFORE PLACING IN THE MEDICAL RECORD

NURSE Releasing Patient: _____ Signature _____ Date

ASH Transport Staff *(If applies)*: _____ Signature _____ Date

ROUTING:
1) Completed copy needs to be ***E-Mailed IMMEDIATELY*** to: **"DHS ASH Visit Out Report"**
2) **ORIGINAL** *(With hand-written signatures)* needs to go in the MEDICAL RECORD

Nursing

Arkansas State Hospital
Comfort Area Sign In / Sign Out Sheet
Unit _____

	Date	Patient Name	Signature	Time In	Time Out
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					

Nursing

DEPARTMENT OF HEALTH & HUMAN SERVICES DIVISION OF BEHAVIORAL HEALTH SERVICES ARKANSAS STATE HOSPITAL DEPARTMENT OF NURSING COMFORT AREA CHECK SHEET	PATIENT ID LABEL

Date:

Patient's stated reasons for using the Comfort Area:

_____

_____

_____

_____

_____

Staff Name (Print) _____ Signature _____ Date _____

Time	Patient Behavior	Staff Signature
Entrance to Comfort Area		
15 min check		
30 min check		
45 min check		
60 min check		

Therapeutic Results:

_____

_____

_____

_____

_____

Staff Name (Print) _____ Signature _____ Date _____

Nursing

DEPARTMENT OF HUMAN SERVICES DIVISION OF BEHAVIORAL HEALTH SERVICES ARKANSAS STATE HOSPITAL	
NURSING SUICIDE RISK RE-ASSESSMENT	**PATIENT ID LABEL**

Date: _____ Time: _____

NOTE: At the beginning of each 12 hour shift (7A – 7P, or 7P – 7A) the unit Charge Nurse will assess patients for suicide risk for whom the physician has ordered suicide precautions.

1. Are you having suicidal thoughts now?
   ☐ No ☐ Yes Is suicidal ideation continuing? If Yes, give example(s):
   _____

2. If # 1 above is Yes, is there evidence of intent (if suicidal ideation continues)?
   ☐ N/A ☐ Yes If Yes, check examples of intent below:
   (a) ☐ No ☐ Yes Subjective statements (e.g., "I think", or "I feel")? If Yes, give example(s):
   _____
   (b) ☐ No ☐ Yes Any preparation or rehearsal behaviors? If Yes, give example(s):
   _____
   (c) ☐ No ☐ Yes Any observed changes in stated reasons for dying or living? If Yes, describe:
   _____

3. Daily symptom severity ratings: (descending order: 5 is the highest, 1 is the lowest)

Depression	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
Anxiety	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
Anger	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
Agitation	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
Sleep	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
Being a burden	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
Impulsivity	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	
Hopelessness	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	

4. Observed changes in mental status

Alertness:	☐ Alert	☐ Drowsy	☐ Lethargic	☐ Stuporous	
	☐ Other: _____				
Oriented to:	☐ Person	☐ Place	☐ Time	☐ Reason for evaluation	
Mood:	☐ Euthymic	☐ Elevated	☐ Dysphoric	☐ Agitated	☐ Angry
Affect:	☐ Flat	☐ Blunted	☐ Constricted	☐ Appropriate	☐ Labile
Thought continuity	☐ Clear & coherent	☐ Goal-directed	☐ Tangential	☐ Circumstantial	
	☐ Other: _____				
Thought content	☐ W/in normal limits	☐ Obsessions	☐ Delusions	☐ Ideas of reference	
	☐ Bizarreness	☐ Morbidity			
Abstraction:	☐ W/in normal limits	☐ Notably concrete			
	☐ Other: _____				
Speech:	☐ W/in normal limits	☐ Rapid	☐ Slow	☐ Slurred	☐ Incoherent
	☐ Impoverished	☐ Other: _____			
Memory:	☐ Grossly intact	☐ Other: _____			
Reality testing:	☐ W/in normal limits	☐ Other: _____			

Nursing

Patient name: _____ Unit _____

4. Observed changes in mental status (continued from page 1)
   Notable behavior observations _____
   _____

5. Current treatment compliance, participation rating
   Is the patient showing evidence of commitment to treatment and actively participating in care?
   ☐ No participation ☐ Minimal ☐ Average ☐ Good ☐ Excellent

Daily Rating of Acute Suicide Risk (check appropriate condition)

- ☐ **Severe:** Specific suicidal thinking (plan) with active intent (observed or stated) **Notify Dr. immediately**
- ☐ **Moderate:** Specific suicidal thinking (plan) with no intent **Notify Dr. immediately**
- ☐ **Mild:** Infrequent, non-specific suicidal thinking (no plan) with no intent
- ☐ **None:** No active suicidal thinking today

☐ Physician notified ☐ No ☐ Yes ☐ N/A Date notified: _____ Time notified: _____
If Yes, name of physician: _____
☐ Orders received ☐ No ☐ Yes ☐ N/A Date received: _____ Time received: _____
Physician's order: _____
☐ Communicated findings to on-coming shift – Charge RN name (print) _____

Nurse RN name & title (print)	Signature	Date	Time
_____	_____	_____	_____

Nursing

DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
ARKANSAS STATE HOSPITAL
DEPARTMENT OF NURSING

MEDICATION TEACHING & OTHER
(WEEKLY BY LPN)

PATIENT ID LABEL

TEACHING: MEDICATION AND OTHER (WEEKLY by LPN)

	Init	Time	MEDICATION	Verbalized correctly? Yes	Verbalized correctly? No	Questions asked & answered? Yes	Questions asked & answered? No	Need more education? Yes	Need more education? No	Refused to participate? Yes	Refused to participate? No
1			Medication name								
2			Medication doses								
3			Medication use								
4			Significant side effects								
5			Medication admin times								
6			Proper storage & disposal								
7			Dangers of medication cheeking								
8			Food & drug interactions								
9			Diabetes education								
10			Safe use of medical equipment								
11			Other: _____								

Day	Print name, title	Initials	Night	Print name, title	Initials
7A-7P			7P-7A		
7A-7P			7P-7A		
7A-7P			7P-7A		

Narrative

Teaching: Nurse's name (print) Signature Date

Nursing

Bedside GLUCOMETER Testing - QUALITY CONTROL LOG

FAX completed log to INFECTION PREVENTION at: 686-9012

Quality controls must be completed DAILY when in regular use; at least WEEKLY when not in regular use AND whenever new test strips or control solutions are opened.

NOTE: EXPIRATION DATES of the HI and LO CONTROL SOLUTIONS MUST BE 90-DAYS AFTER THE SOLUTION IS OPENED, NOT THE DATE PRINTED ON THE BOTTLE.

UNIT:	HI Control Lot #	EXP DATE:	ACCEPTABLE RANGE:
	LO Control Lot #	EXP DATE:	ACCEPTABLE RANGE:
SERIAL #:	HI Control Lot #	EXP DATE:	ACCEPTABLE RANGE:
	LO Control Lot #	EXP DATE:	ACCEPTABLE RANGE:
MONTH / YEAR:	*CIRCLE whether:* DAILY *or* WEEKLY *controls are required for this unit*		

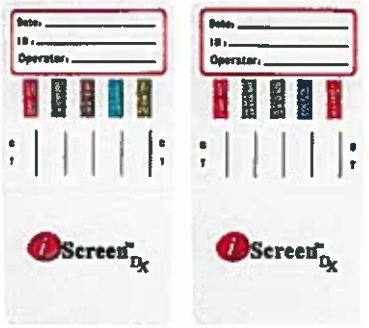
Day of Month	Time	HI - Result	LO - Result	Within Acceptable Range? (Y / N)	Test Strip Code	Test Strip Lot #	Test Strip EXP Date	Cleaned? (Y / N)	Name / Title (Print)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									

PROBLEM LOG (Print)

DATE	PROBLEM	ACTION	RESOLVED	NAME

10-Panel URINE DRUG SCREEN

Interpretation of Results



FRONT (5 Panels) BACK (5 Panels)

10-Panel UDS Device

1) **Storage & Stability** Store as packaged in sealed pouch at room temperature.

2) **Specimen Collection and Preparation**
- Urine must be collected in a clean and dry container.
- Specimen collected at any time of day may be used.

3) **Directions For Use**

1. Device must be at room temperature.
2. Label device on the top (both sides) where indicated and remove cap from device.
3. Dip paper test strips into the specimen completely ensuring plastic housing remains above specimen.
4. *Start timer – Remove device from specimen after **10-seconds**.*
5. *Replace cap back onto device and read results at **4-minutes**.*
6. ***Read each screen independently and DO NOT interpret results after 7-minutes.***
7. ***IF POSITIVE MAKE A COPY OF DEVICE and follow chain of command procedure as usual.***
8. ***Chart ALL results in progress notes.***

These drugs and related compounds are tested with the 10-panel screen: AMP – BAR – BZD – COC – MET or Mamp – MDMA or XTC – MOR/OPI – MOR 300 – MTD – OXY – PCP – TCA – THC

POSITIVE

"C" line appears but no "T" line

Test is positive for drug indicated

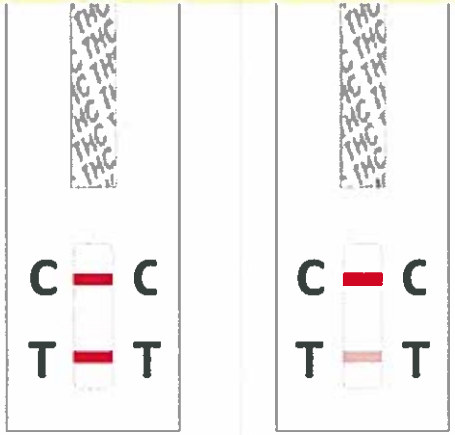
This sample screen shows a POSITIVE result for marijuana (THC)

NEGATIVE

"C" line and "T" line appears

Test is negative for drug indicated

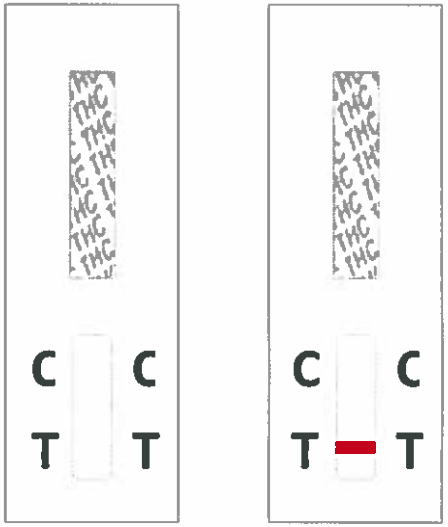
***Intensity* of LINE COLOR is not a factor**
Even a *FAINT LINE* indicates NEGATIVE RESULT



INVALID

No "C" line develops within 4-minutes

Test is invalid; Repeat test



Nursing

B.Reohr/Nursing Administration

DEPARTMENT OF HUMAN SERVICES DIVISION OF BEHAVIORAL HEALTH SERVICES ARKANSAS STATE HOSPITAL DEPARTMENT OF NURSING URINE DRUG SCREEN RESULTS	PATIENT ID LABEL

Date of Test: _____ **Time Test Performed by ASH:** _____

ASH TEST RESULTS

DRUG NAME	Abbreviation	Pos	Neg
Amphetamine	AMP	☐	☐
Barbiturates	BAR	☐	☐
Benzodiazapine	BZO	☐	☐
Cocaine	COC	☐	☐
Marijuana	THC	☐	☐
Methadone	MTD	☐	☐
Methamphetamine	mAMP	☐	☐
Methylenedioxymethamphetamine	MDMA	☐	☐
Morphine	MOP 300 or OPI 300	☐	☐
Opiates	OPI 2000	☐	☐
Phencyclidine	PCP	☐	☐
Tricyclic	TCA	☐	☐

Please place an "X" by the appropriate results above

Physician informed of positive results: Yes: ☐ No: ☐

Date: _____ **Time:** _____

Physician ordered independent test? Yes: ☐ No: ☐

Date: _____ **Time:** _____

Test request sent to specified lab vendor: Yes: ☐ No: ☐

Date: _____ **Time:** _____

_____ _____

Staff Name (Printed) Staff Signature

_____ _____ _____

Physician's Name (Printed) Physician's Signature Date

Nursing

URINE PREGNANCY TEST *Interpretation of Results*

1) Storage & Stability

Store as packaged in sealed pouch at 2-30 degrees Celsius.
The test dipstick is stable through the expiration date printed on the sealed pouch.
DO NOT FREEZE ***DO NOT USE BEYOND EXPIRATION DATE***

2) Specimen Collection and Preparation

- A first morning urine specimen is preferred since it generally contains the highest concentration of hCG; however, urine specimen collected at any time of the day may be used.
- Urine must be collected in a clean and dry container.
- Visible precipitates should be centrifuged, filtered, or allowed to settle to obtain a clear specimen for testing.

3) Directions For Use

Test Dip-Stick Device:

1. Remove test dipstick from sealed pouch and use as soon as possible.
2. With arrows pointing toward urine specimen immerse test dipstick vertically in urine for at least 5 seconds.
   - ***DO NOT pass MAX line on test strip when immersing***
3. Place test dipstick on a non-absorbent flat surface; start the timer and wait for red line(s) to appear.
4. **READ *RESULTS AT 3-4 MINUTES. DO NOT INTERPRET RESULTS AFTER APPROPRIATE READ TIME.***
5. Chart ALL results in progress notes.

POSITIVE

***TWO DISTINCT* red lines appear**
One line should be in the control region (C)
Another line should be in the test region (T)

NOTE *Intensity of red color in test line region (T) will vary depending on concentration of hCG present.*

NEGATIVE

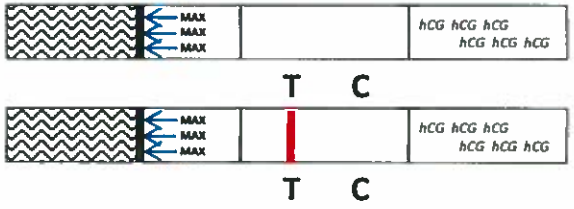
***ONE RED LINE* appears in control region (C)**

NO apparent red or a pink line appears
in test region (T)

INVALID

Control line *FAILS* to appear

Insufficient specimen volume or incorrect procedural techniques are the most likely reasons for control line failure. Preview procedure and repeat test with a new test dipstick.



Nursing

B.Reohr/Nursing Administration

Nursing Services Charge Tickets

Date:

Staff Initials	Patient Sticker	Personal Item	Personal Item	Supplement
		☐ Admit kit MS 216 ☐ Comb MS 167 ☐ Deodorant MS 170 ☐ Hair conditioner MS 212 ☐ Hair grease MS 247 ☐ Hair oil MS 213 ☐ Kotex MS 127 ☐ Laundry soap MS 215 ☐ Shampoo MS 211	☐ Shower shoes MS 249 ☐ Slippers MS 181 ☐ Styling gel MS 210 ☐ TB cover MS 248 ☐ Toothbrush MS 177 ☐ Toothpaste MS 178 ☐ ________	☐ Boost DT 116 ☐ Ensure DT 108 ☐ Glucerna DT 117 ☐ Mighty Shake DT 111 ☐ Gatorade DR 109 ☐ V-8 Juice
		☐ Admit kit MS 216 ☐ Comb MS 167 ☐ Deodorant MS 170 ☐ Hair conditioner MS 212 ☐ Hair grease MS 247 ☐ Hair oil MS 213 ☐ Kotex MS 127 ☐ Laundry soap MS 215 ☐ Shampoo MS 211	☐ Shower shoes MS 249 ☐ Slippers MS 181 ☐ Styling gel MS 210 ☐ TB cover MS 248 ☐ Toothbrush MS 177 ☐ Toothpaste MS 178 ☐ ________	☐ Boost DT 116 ☐ Ensure DT 108 ☐ Glucerna DT 117 ☐ Mighty Shake DT 111 ☐ Gatorade DR 109 ☐ V-8 Juice
		☐ Admit kit MS 216 ☐ Comb MS 167 ☐ Deodorant MS 170 ☐ Hair conditioner MS 212 ☐ Hair grease MS 247 ☐ Hair oil MS 213 ☐ Kotex MS 127 ☐ Laundry soap MS 215 ☐ Shampoo MS 211	☐ Shower shoes MS 249 ☐ Slippers MS 181 ☐ Styling gel MS 210 ☐ TB cover MS 248 ☐ Toothbrush MS 177 ☐ Toothpaste MS 178 ☐ ________	☐ Boost DT 116 ☐ Ensure DT 108 ☐ Glucerna DT 117 ☐ Mighty Shake DT 111 ☐ Gatorade DR 109 ☐ V-8 Juice
		☐ Admit kit MS 216 ☐ Comb MS 167 ☐ Deodorant MS 170 ☐ Hair conditioner MS 212 ☐ Hair grease MS 247 ☐ Hair oil MS 213 ☐ Kotex MS 127 ☐ Laundry soap MS 215 ☐ Shampoo MS 211	☐ Shower shoes MS 249 ☐ Slippers MS 181 ☐ Styling gel MS 210 ☐ TB cover MS 248 ☐ Toothbrush MS 177 ☐ Toothpaste MS 178 ☐ ________	☐ Boost DT 116 ☐ Ensure DT 108 ☐ Glucerna DT 117 ☐ Mighty Shake DT 111 ☐ Gatorade DR 109 ☐ V-8 Juice
		☐ Admit kit MS 216 ☐ Comb MS 167 ☐ Deodorant MS 170 ☐ Hair conditioner MS 212 ☐ Hair grease MS 247 ☐ Hair oil MS 213 ☐ Kotex MS 127 ☐ Laundry soap MS 215 ☐ Shampoo MS 211	☐ Shower shoes MS 249 ☐ Slippers MS 181 ☐ Styling gel MS 210 ☐ TB cover MS 248 ☐ Toothbrush MS 177 ☐ Toothpaste MS 178 ☐ ________	☐ Boost DT 116 ☐ Ensure DT 108 ☐ Glucerna DT 117 ☐ Mighty Shake DT 111 ☐ Gatorade DR 109 ☐ V-8 Juice
		☐ Admit kit MS 216 ☐ Comb MS 167 ☐ Deodorant MS 170 ☐ Hair conditioner MS 212 ☐ Hair grease MS 247 ☐ Hair oil MS 213 ☐ Kotex MS 127 ☐ Laundry soap MS 215 ☐ Shampoo MS 211	☐ Shower shoes MS 249 ☐ Slippers MS 181 ☐ Styling gel MS 210 ☐ TB cover MS 248 ☐ Toothbrush MS 177 ☐ Toothpaste MS 178 ☐ ________	☐ Boost DT 116 ☐ Ensure DT 108 ☐ Glucerna DT 117 ☐ Mighty Shake DT 111 ☐ Gatorade DR 109 ☐ V-8 Juice

Assigned staff turns in used sheets daily, beginning of each shift Monday - Friday. Each day starts with clean sheets. Sheets from weekend and holiday are turned in the next business day.

Initial: _____ Name / # (print)____________ Initial: _____ Name / # (print)____________ Initial: _____ Name / # (print)____________
Initial: _____ Name / # (print)____________ Initial: _____ Name / # (print)____________ Initial: _____ Name / # (print)____________
Initial: _____ Name / # (print)____________ Initial: _____ Name / # (print)____________ Initial: _____ Name / # (print)____________

Nursing

Blood Sugar Finger Stick Charge Tickets

Patient Sticker	Date Time	Staff Signature	Clinician Code
	Date Time		
	Date Time		
	Date Time		
	Date Time		
	Date Time		
	Date Time		
	Date Time		
	Date Time		

Designated staff will turn in used sheets daily at beginning of each shift Monday - Friday, and will start each day with clean sheets. Sheets from weekend and holiday to be turned in the next business day.

Nursing

ARKANSAS ARREST/DISPOSITION REPORT

DEFENDANT IDENTIFICATION

Arresting Agency Name	Case Number

Name Last	First	Middle

Aliases

Street Address	Phone No.

City & State	Zip

Central System No.	F. B. I. No.	State I.D. No.

Social Security No.	Drivers License No. & State

Sex	Race	Date of Birth	Place of Birth
☐ M ☐ F	1 ☐ White 3 ☐ Oriental 5 ☐ Other 2 ☐ Negro 4 ☐ Amer. Indian 6 ☐ Unknown		

Hair	Eyes	Weight	Height	Scars and Marks

Complexion	Build	Employer/Occupation

Name of Nearest Relative	Phone No. -----

Street Address	City, State, Zip

ARREST

PLEASE PRESS HARD – You are making four copies

Place of Arrest	Arresting Officers

Date of Arrest	Time of Arrest	Bail Amount Set	Offense No.	Arrestee received from another L.E. Agency
				1 ☐ Yes 2 ☐ No

	Classification Felony/Misdemeanor	Warrant Number	State Crim. Code	Charge Description	Disposition	Date (Mo. Day, Yr.)
1				)		
2						
3						
4						

Facts of Arrest (Explain in Detail)

Court Date	Court Hearing Case	Phone	Right Thumb Print (Here & On Back)
Complainant	Home		
	Business		
Witness	Home		
	Business		
Witness	Home		
	Business		

Tracking Number

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ACIC Arkansas Crime Information Center N.C.I.C. POLICE ASH

ARKANSAS STATE HOSPITAL POLICE DEPT. CRIMINAL JUSTICE INFORMATION SECURITY REPORT

ATTN: INFORMATION SECURITY OFFICER

AR STATE HOSPITAL POLICE DEPT.

305 S. Palm St. , Little Rock Arkansas 72205

REPORT DATE: **REPORTED BY:**

REPORT TIME:

1. ON WHAT DATE DID THE INCIDENT OCCUR?

2. LOCATION OF THE INCIDENT?

3. WHAT SYSTEMS WERE AFFECTED?

4. WHAT METHOD OF DETECTION WAS USED?

5. WHAT IS THE NATURE OF THE INCIDENT?

6. PROVIDE A BRIEF DESCRIPTION OF THE INCIDENT:

7. WHAT ACTIONS WERE TAKEN, OR HOW WAS THIS INCIDENT RESOLVED?

Received By:_____ **DATE :**_____ **TIME:**_____**4/7/2017**

INFORMATION SECURITY OFFICER PRINTED NAME

_____

INFORMATION SECURITY OFFICER SIGNATURE

REPORTED TO ACIC: _____ _____ _____

DATE TIME ACIC PERSON RECEIVING REPORT

PSO

Arkansas State Hospital
Department of Public Safety

Evidence Report and Chain of Custody

Incident #		Date of Report			
Classification/Charge		Offense Discription			
Property taken from (Location)					
Date taken		Time		Owner	

Item Description:

Item #	Description (Make, Model, S/N, Identifying Marks)

Chain of Custody

From (Print)		Date/Time	To (Print)		
Signature			Signature		Evidence
From (Print)		Date/Time	To (Print)		
Signature			Signature		Evidence
From (Print)		Date/Time	To (Print)		
Signature			Signature		Evidence
From (Print)		Date/Time	To (Print)		
Signature			Signature		Evidence
From (Print)		Date/Time	To (Print)		
Signature			Signature		Evidence
From (Print)		Date/Time	To (Print)		
Signature			Signature		Evidence
From (Print)		Date/Time	To (Print)		
Signature			Signature		Evidence

P80

ARKANSAS STATE CRIME LABORATORY

EVIDENCE SUBMISSION FORM

P.O. Box 8500
3 Natural Resources Drive
Little Rock, Arkansas 72215
Phone: (501) 227-5747

www.arkansas.gov/crimelab

P.O. Box 868
Hope, Arkansas 71802
Phone: (870) 722-8530
Fax: (870) 722-8534

*denotes required field

*Has any evidence been previously submitted on this case by any agency? ☐ Yes ☐ No		
*Investigating Agency **Arkansas State Hospital Police Department**	*Agency Case Number	ASCL Case Number
Type of Offense	*Date of Offense	*County of Offense
*Investigating Officer (Last, First)		Phone
E-Mail Address:		Mobile

Suspect(s) Name(Last, First)	SID	DOB	Race	Sex	Victim(s) Name (Last, First)	SID	DOB	Race	Sex

*Evidence #	*Evidence Description	Lab Use	Examination Areas(s)
			☐ Digital Evidence
			☐ Drug Analysis
			☐ Firearms/Toolmarks
			☐ Illicit Laboratories
			☐ Latent Prints
			☐ Operation Shutdown/NIBIN
			☐ Physical Evidence/DNA
			☐ Toxicology

By signing, I hereby certify all listed firearms are unloaded:	Signature	Date

*Type of Analysis Requested:	LAB USE ONLY
Detailed Summary of Crime (Use provided addendum if necessary):	
*Submitting Officer (print):	
*Signature	HC USPS UPS FDX DHL

P80

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY
MIRANDA RIGHTS

INCIDENT #_____

NAME: _____ **DOB:** _____

ADDRESS: _____

EDUCATION LEVEL COMPLETED: _____

I AM ABLE TO READ AND WRITE: **YES** ☐ **NO** ☐

1. **Do you understand that you have right to remain silent?**
   Response: _____
2. **Do you understand that anything you say can and will be used against you in a court of law?**
   Response: _____
3. **Do you understand that you have the right to talk to an attorney and to have an attorney present during questioning?**
   Response: _____
4. **Do you understand that if you cannot afford and attorney, one will be provided for you at no cost to you if you so desire?**
   Response: _____
5. **Do you understand that you can stop the questioning at any time?**
   Response: _____

I have read and / or have had my rights read to me as stated above, which I fully understand as witnessed by my initials above and my signature below:

SIGNATURE: _____

OFFICER(S) SIGNATURE: _____

WITNESSED BY: _____

DATE / TIME: _____

LOCATION: _____

P80

ARKANSAS STATE HOSPITAL
DEPARTMENT OF PUBLIC SAFETY

MIRANDA RIGHTS

Hospital estatal de Arkansas

Departamento de seguridad pública

Las derechas de Miranda

INCIDENT #_____

NAME:
Nombre: _____

DATE OF BIRTH:
Fecha de nacimiento: _____

ADDRESS:
Dirección: _____

EDUCATION LEVEL COMPLETED:
Nivel de la educación terminado: _____

I AM ABLE TO READ AND WRITE: **YES** ☐ **NO** ☐
Puedo leer y escribir: *Sí* *NO*

1. **Do you understand that you have right to remain silent?**
   Usted entiende que usted hace que la derecha a siga siendo silenciosa?
   Response: _____ *Respuesta:*

2. **Do you understand that anything you say can and will be used against you in a court of law?**
   Usted entiende que cualquier cosa que usted dice puede y será utilizado contra usted en un tribunal de justicia?
   Response: _____ *Respuesta:*

3. **Do you understand that you have the right to talk to an attorney and to have an attorney present during questioning?**
   Usted entiende que usted tiene la derecha de hablar con un abogado y tenga un abogado presente durante preguntar?
   Response: _____ *Respuesta:*

4. **Do you understand that if you cannot afford and attorney, one will be provided for you at no cost to you if you so desire?**
   Usted entiende que si usted no puede permitirse a un abogado, proporcionarán uno para usted en ningul un coste usted si usted desea tan?
   Response: _____ *Respuesta:*

5. **Do you understand that you can stop the questioning at any time?**
   Usted entiende que usted puede parar preguntar en cualquier momento?
   Response: _____ *Respuesta:*

I have read and / or have had my rights read to me as stated above, which I fully understand as witnessed by my initials above and my signature below:
He leído y/o he hecho las mis derechas leer a mí como se declaró anteriormente, que entiendo completamente según lo atestiguado por mis iniciales arriba y mi firma abajo:

SIGNATURE:
Firma: _____

OFFICER(S) SIGNATURE: _____

WITNESSED BY: _____

DATE / TIME: _____

LOCATION: _____

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Arkansas Crime Information Center
State Sex Offender Registry
Change of Address Form for Registered Sex Offenders

You must complete the following information and submit it immediately to the local law enforcement agency to which you report. The agency will mail or FAX this information to the Arkansas Crime Information in order for your record to be promptly updated. Failure to report any change of address as required by Act 989 of 1997 as amended constitutes a Class C Felony and may result in subsequent arrest and prosecution.

Please type or print clearly:

Form completed by: _____ **Date form completed:** _____
(If other than offender)

Jurisdictional Agency Name (at new place of residence): _____

Duplicate VOR Requested Yes ☐ **No** ☐ (if the offender is delinquent, a duplicate VOR must be requested by jurisdictional agency)

Offender's Name (please print): _____ **Race:** ___ **Sex:** _____

Date of Birth: _____ **Social Security No:** _____

Previous Address:

_____
Street name or Rural Route & box number

_____
City State Zip

Institute of Higher Education:

_____
Name of institution (if currently attending)

Place of Employment:

_____
Name of employer (company or individual)

_____
Address (street name, number or box number)

_____
City State Zip

Vehicle(s) Information:

_____
Year/make/ model /color vehicle license number

_____
Name of registered owner if not your own

_____
Signature of offender **(required)**

_____
Date signed **(required)**

New Mailing Address: (may use PO Box if not your residence)

_____
Street name or Rural Route & box or PO Box number

_____
City State Zip

Telephone No. ( )_____

Date moved or planning to move: _____

New Place of Residence: If different from new mailing address: (DO NOT use Post Office Box for residential address) If you are living in a vehicle or other vessel use separate sheet for further information

_____
Street name or Rural Route & Box number

_____
City State Zip

If new place of residence has been physically verified, sign below:

_____ _____
Law enforcement official only **date verified**

Email addresses currently used and all IM screen names used and any social web pages registered (MySpace, Facebook, etc:

_____

_____

_____

Sex Offender Registration Form

Reporting this information is required by ACA §12-12-904. This form shall be sent to the Arkansas Crime Information Center within 3 days after completion for entry into the state and national Sex Offender Registration Files.

Type or Print (Ink Only)

Sentencing Court

Offender's Last Name	First Name	Middle Name	AKA or Alias Last Name	First Name	Middle Name

Date of Birth	Race	Sex	Height Ft In	Weight	Hair Color	Eye Color	Social Security #

AR SID (if offender does not have AR SID please submit 2 sets of prints with registration)	FBI #	Driver License or ID Card #	State of DL or ID Card

Scars/Marks/Tattoos

Vehicle used by offender	License #/ state	Make/Model	Color	Owner of vehicle if not offender:

Sex Offense Information (If additional space is needed, list on separate sheet and attach to this form)

Date of conviction	Arresting Agency	Offense for which found guilty or acquitted by reason	Arrest Tracking #
Date of conviction	Arresting Agency	Offense for which found guilty or acquitted by reason	Arrest Tracking #

Institute of Higher Education (known or anticipated) **(If currently attending/volunteering/employed, check here)** ☐

Name of Institute	Location

Residence Information (including houseboat or any type of vessel)

Street #, Street Name; RR # & Box; Apt #; Mobile Home # (Do not use P.O. Box here)				
City	County	State	Zip	Phone #
If residence is vessel/vehicle ID number	Color/description	License #		

Mailing Address (if different from residence, for example P.O.Box)

Street #, Street Name; RR # & Box; Apt #; Mobile Home # or P.O. Box #		
City	State	Zip
Misc. information		

Place of Employment---date employed_____

Name of Employer (company and/or individual)	Street #, Street Name/ RR# & Box	City	State	Zip	Phone #

Brief Description of the Crime(s) for which this registration is required (If additional space is needed, list on separate sheet and attach to this form)

Victim Information	Age Victim 1	Race Victim 1	Sex Victim 1	Offender Relationship to Victim 1	Age Victim 2	Race Victim 2	Sex Victim 2	Offender Relationship to Victim 2

Email address and IM information: (including all screen names used, Myspace, Facebook, etc.)

_____

_____

Acknowledgement by Offender

I hereby acknowledge that I have been advised of my duty to register as a sex offender, or sexually violent predator, as required by Arkansas ACA §12-12-904. I have also been advised that failure to regularly verify my address or failure to report any change of address as required under ACA §12-12-904 constitutes a Class C Felony and may result in my subsequent arrest and prosecution.

(REQUIRED INFORMATION)

Registering Agency or Court one)	Campus Registration? YES NO (circle
Address	City and Zip
Name (Printed) of official completing this form	Area Code & Phone #

_____
Signature of Offender

_____
Date signed

This Form shall be faxed or mailed by the criminal justice agency to the Arkansas Crime Information Center, One Capitol Mall, Little Rock, AR 72201 FAX 501-683-5592 Failure to complete and forward to ACIC by the registering agency within 3 days after registration of an offender is a Class B Misdemeanor under ACA § 12-12-904.

(ACIC SOR Form 09-15-08)

PSO