Hospital Admission Checklist

Key contact: Clinical Leader Name and Contact Info: Name: _____	Phone # _____ Fax# _____ E-Mail _____	Patients Name: _____ DOB: _____ PCP: _____
Residential Contact Info: _____ Agency Nurse: _____	Phone # _____ Fax# _____ Phone # _____	Guardianship status: ☐ Self ☐ Assigned Guardian Contact Name _____ Phone # _____ Healthcare proxy: _____ _____ Invoked Yes ☐ No ☐

Agency Rules for Agency Sitters:

Monitor Only ☐	Feed Yes ☐ No ☐	Bathe Yes ☐ No ☐	Assist BR/Ambulation Yes ☐ No ☐
Hospital sitter Yes	No	Risk of Fall Yes No	**Over Night**

☐ Reconciliation of Medications/ Diet/Treatment Plan

☐ Update contact Info and Compare with Demographic Sheet in chart

Additional comments/Information

Hospital Contact Info

Floor/Floor Telephone Number		
Fax# _____		
Agency Staff Person providing Info _____	Date _____ Time _____	Agency Staff Signature _____